Interim Report

of

Committee on Medical Care

Maryland State Planning Commission

January — 1947

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MARYLAND STATE PLANNING COMMISSION

104 Equitable Building
Baltimore 2, Maryland

February 1, 1947

Honorable William Preston Lane, Jr.
Governor of Maryland
Annapolis, Maryland

My dear Governor Lane:

I take pleasure in transmitting herewith, for your consideration, the Interim Report to January, 1947 of the State Planning Commission's Committee on Medical Care. Contained therein are several important recommendations, notably:

1. That the responsibilities of the Baltimore City Health Department be extended to make them comparable to those previously approved for the State Health Department, having as the first objective the establishment of a program of medical care for the indigent of Baltimore City complementing that already established in the counties of Maryland;
2. That the responsibility for administering the State's tuberculosis program be transferred from the Maryland Tuberculosis Commission to the State Department of Health;
3. That certain legislation necessary to implement and comply with the provisions of the Federal Hospital Survey and Construction Act be enacted;
4. That certain projects now before the Board of Public Works in the construction programs of the State Board of Mental Hygiene, the University of Maryland, and the State Health Department, be pressed to completion;
5. That the State Board of Health be vested with the responsibility for maintaining a program of Mental Hygiene integrated with, but in addition to, the institutional program of the Board of Mental Hygiene; and
6. That the Chronic Disease Hospital, "to be located in or near Baltimore," as authorized by the last Legislature, be built on the grounds of the Baltimore City Hospitals.

The Commission and the State is fortunate in having a group of men, such as that comprised in the Committee on Medical Care, so eminently qualified and so willing, without any hope of personal gain or advantage, to undertake the serious responsibility imposed by the original charge to the Committee "to keep under constant survey the problems of medical care for the citizens of this State and to formulate from time to time recommendations for better utilization and for extension of existing medical facilities and for the institution of such new facilities as are required."

The Commission in approving the recommendations of the Committee, believes that its work is of such caliber as to continue to merit your support, as well as that of the public and the professional groups involved.

Respectfully yours,

Henry P. Irr

HENRY P. IRR, *Chairman*

MARYLAND STATE PLANNING COMMISSION

104 Equitable Building
Baltimore 2, Maryland

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Director

January 27, 1947

Mr. Henry P. Irr, Chairman
Maryland State Planning Commission
Baltimore, Maryland

Dear Mr. Irr:

I have the honor to transmit herewith the Interim Report of the Committee on Medical Care, recording its activities since the publication of its last report in April, 1944.

Despite the limited resources available to the Committee, it has, through the ingenuity and self-sacrifice of its members, been able to complete an impressive agenda out of which have grown some significant recommendations for action.

These recommendations are stated herein and deserve careful consideration by your Commission, the State Administration, the Legislature, and by the public. We trust they will bear such scrutiny and will be translated into action.

While important recommendations growing out of the work of our Sub-Committee to Study the Medical Care Needs of Baltimore City, and out of the work of the Hospital Survey Committee are included in this report, both of these Committees are still at work. We may expect further recommendations from them for consideration by the Committee on Medical Care and your Commission.

You also will note that the Committee hopes to find financial support for a review of the tuberculosis program in Maryland. Such review, it feels, is particularly appropriate because of the recommended transfer of the responsibilities in this field from one State agency to another.

The continuing support of the work of the Committee by your Commission and its staff is gratefully acknowledged.

Sincerely yours,

Maurice C. Pincoffs

Maurice C. Pincoffs, M.D., *Chairman*
Committee on Medical Care

INTRODUCTION

In the two prewar years immediately following the formation of the Committee on Medical Care in January 1940, the major efforts of the Committee might be classified as "self-education." It soon became apparent that the most immediate problem existed in the counties of Maryland, and during 1941 a thorough survey of medical care in the counties of Maryland was undertaken. The coming of war prevented the completion of this program, but a body of data had been accumulated which was to prove of great value.

In the war years 1942 and 1943 the activities of the Committee were greatly restricted. However, during this period, the data gathered in the field survey were analyzed and the conclusions presented in the report of the Committee issued in April, 1944. The major recommendation of this report was that there be created a Bureau of Medical Services within the State Department of Health, responsible for administering a program of medical care for the indigent and medically indigent in the counties of Maryland. Legislation establishing such a bureau was passed by the 1945 Legislature. In addition, the data of the Committee gave timely assistance to the staff of the Procurement and Assignment Service in meeting both its local and national problems in providing adequate professional staff for the armed services without crippling essential local services.

Since the publication of its report in April, 1944, both during the later war period and since, the Committee has engaged in the study of various aspects of medical care in Maryland. These activities and their results to date are summarized in the present interim report.

Early in the war the Chairman of the Committee, Dr. Maurice C. Pincoffs, left for service with the armed forces. He was succeeded by Dr. Allen W. Freeman, who served as acting Chairman of the Committee for a short time, and then by Dr. Victor F. Cullen, who in characteristic fashion gave liberally of his time and energy to the affairs of the Committee. Dr. Pincoffs returned to civilian life in the fall of 1946, at which time Dr. Cullen resigned as acting Chairman and Dr. Pincoffs resumed his activity as Chairman of the Committee.

ACTIVITIES OF THE COMMITTEE ON MEDICAL CARE

April 1944 to January 1947

The activities of the Committee in greater part have been carried on through special sub-committees appointed to study specific aspects of medical care in the State. In addition, meetings of the Executive Committee have been held to consider points of policy and future plans. The entire Committee has been called together to receive and consider the reports made to it by the sub-committees. Under separate headings the reports of these special committees and the Executive Committee are summarized together with the action taken by the Committee on Medical Care on each of these reports. Finally, the recommendations of the Committee on Medical Care are presented in a separate section.

Committee on Mental Hygiene

During 1944 the State Board of Mental Hygiene, along with other State departments, prepared an exhaustive program of construction, outlining the major items of new construction and rehabilitation which were to constitute its post-war construction program. These recommendations were referred to the State Planning Commission, which requested the advice of the Committee on Medical Care. Accordingly, on August 11, 1944 a special committee was appointed to review this program. The personnel of the Committee was as follows:

Ross McC. Chapman, M.D.	J. Milton Patterson
Louis H. Douglass, M.D.	Robert H. Riley, M.D.
Walter N. Kirkman	J. C. Whitehorn, M.D.

Alan M. Chesney, M.D., *Chairman*

In November 1944 the special committee submitted its report, which was concurred in by the Committee on Medical Care and the State Planning Commission and forwarded to the Board of Public Works. The essential features of this Committee's report are as follows:

> "The Committee voted to approve in principle all of the proposals of the State Board of Mental Hygiene designed to meet the immediate needs for the care of the mentally ill of the State, including the recommendation that a psychopathic hospital be constructed as an integral part of the School of Medicine of the University of Maryland. The Committee wishes to point out that the State even now is far behind in its program of construction to meet the expanding needs for the care of the mentally ill. The normal increase in population and the concomitant increase in the number of persons requiring care for mental illnesses will not wait for a board to approve or a legislature to act. Mental illness is not going to decline in incidence—rather will it increase as life expectancy increases. Increasing urbanization also increases the need for State hospital beds. The Committee is convinced that the general program presented by the Board of Mental Hygiene is sound and by no means an excessive one. Indeed it may well be designated a minimal program designed to meet only the immediate needs and absolutely essential to bring the provisions for care of the mentally ill up to the level where they really should be if the State of Maryland is to discharge its obligations in a proper manner.
>
> "The Committee gave some consideration to the question of the relative values of the specific proposals, but quickly came to the conclusion that it was not in a position to evaluate one proposal as against another because all of the proposed facilities constitute a single unified system for the care of the mentally ill. Consequently, it does not endorse any particular schedule of construction or recommend that one unit be given preference over another. It does wish to point out, however, that dollars spent in the construction of the proposed psychopathic hospital would yield a two-fold dividend. They would provide an important link in the State's system of professional education (medical students, physicians, nurses, technicians) and at the same time make a substantial contribution to the care of the mentally ill. The Committee sees no reason why the construction of this hospital should await the completion of all the other units that have been proposed; it feels that the best interests of the mentally ill will be served if construction of all of the units proceeds at the same time."

Following the submission and acceptance of this report, the Special Committee was discharged with thanks by Dr. Victor Cullen, Acting Chairman.

Committee to Study the Medical Care Needs of Baltimore City

In accordance with its previously announced intention, the Committee on Medical Care, in 1944, laid plans to undertake the second step of its program, which was to study the complex medical needs of Baltimore City. The Committee was fortunate in securing Dr. Lowell J. Reed to serve as Chairman of this important undertaking. In August, 1944, the appointment of the Committee was announced, with the following personnel:

Lowell J. Reed, Ph.D., *Chairman*
George M. Anderson, D.D.S.
Edwin L. Crosby, M.D.
C. Reid Edwards, M.D.
Herbert Fallin
Frank Geraghty, M.D.
L. Edwin Goldman
Thomas P. Sprunt, M.D.
T. J. S. Waxter
Harvey H. Weiss
H. Maceo Williams, M.D.
Huntington Williams, M.D.
Samuel Wolman, M.D.
W. H. Woody, M.D.
Ross Cameron, M.D., ex officio
J. D. Colman, ex officio
Maurice C. Pincoffs, M.D., ex officio
Dean Roberts, M.D., ex officio

Through the cooperation of the Baltimore City Department of Health and the Maryland State Planning Commission, the services of Dr. W. Thurber Fales were secured as Director of Survey. This Committee has been actively at work and has accumulated a vast amount of data concerning many phases of the medical care problem. The understanding of the Committee has been appreciably broadened by many of the unique tabulations of this material that have been prepared by Dr. Fales and Dr. Reed. Many significant correlations previously unproved, or unrecognized, have been revealed.

These studies of the Committee to Study the Medical Care Needs of Baltimore City led to certain specific recommendations which it was felt required immediate attention by the Committee on Medical Care and by the current session of the General Assembly. For this reason an interim report was prepared and presented to the Committee on Medical Care, and is attached hereto as Exhibit A.

The recommendations of this interim report, if adopted, materially affect the present organization of medical care in the City of Baltimore. In all instances, responsible authorities of the health agencies concerned were fully consulted by the Committee and their concurrence received prior to the formulation of the report. The proposal of a specific program of medical care for public assistance clients in Baltimore involves the cooperation of the larger out-patient departments of the hospitals of the City as well as that of the practicing physicians. Representatives of Dr. Reed's Committee presented these proposals to a special meeting of the Baltimore Hospital Conference, and to a special meeting called by the Baltimore City Medical Society, to which all physicians practicing in Baltimore were invited. In both instances the proposed plan was approved by vote of an overwhelming majority. On December 27, 1946, the interim report of Dr. Reed's Committee was formally presented to the Committee on Medical Care. After discussion, the Committee on Medical Care voted unanimously to approve this report and to include its recommendations in its own report to the State Planning Commission.

Hospital Survey Committee

In anticipation of the passage of Federal legislation providing for grants-in-aid to States for hospital construction, the Committee on Medical Care appointed a Hospital Survey Committee in December, 1945. Later, Congress passed such legislation, now known as the Hospital Survey and Construction Act, P.L. 725-US-1946. Federal funds can be made available to States on a matching basis under certain conditions, the most important of which are that:

(a) The State must designate a single State agency with an appropriate advisory council to make an initial inventory of the hospital facilities of the State and to develop therefrom a plan for such expansion and integration of these facilities as may be found to be necessary, and

(b) The State must designate a single State agency which is to administer the construction phase of the program in accordance with the State plan developed as outlined in (a) above.

Governor O'Conor designated the Maryland State Planning Commission as the agency in Maryland to undertake the survey phases of this program and the Hospital Survey Committee, previously discussed, was selected as the advisory council to this agency, as provided for under the Federal legislation. Dr. Walter D. Wise, the chief of staff of Mercy Hospital, accepted the chairmanship of this Committee, the entire membership of which is as follows:

Walter D. Wise, M.D., *Chairman*
J. D. Colman, *Secretary*
J. David Cordle
W. D. Noble, M.D.
George H. Preston, M.D.
R. H. Riley, M.D.
Winford H. Smith, M.D.
Ernest L. Stebbins, M.D.
Harvey H. Stone, M.D.
Huntington Williams, M.D.
C. E. Wise, Jr.
Benjamin W. Wright
Peregrine E. Wroth, M.D.
Edwin P. Young, Jr.
Ralph Young, M.D.
Maurice C. Pincoffs, M.D., ex officio
I. Alvin Pasarew, ex officio

The necessary budgetary assistance was secured through the State Planning Commission, and Mr. H. G. Fritz was secured as Director of the Survey. The Committee has completed the inventory phase of its work and is now

concerned with the analysis of the data obtained, and with the development of an over-all plan to govern the extension of Maryland's hospital facilities. Attached hereto as Exhibit B is the interim report of this Committee. This interim report was presented to the Committee on Medical Care at its meeting on December 12, 1946. The recommendations made by the Hospital Survey Committee for legislative action necessary to enable the State of Maryland to participate fully in the benefits of the Hospital Survey and Construction Act, were considered carefully and were unanimously approved. In the present report of the Committee on Medical Care to the State Planning Commission these recommendations are included.

Executive Committee

The State's Tuberculosis Program

To obtain full information concerning the advantages and disadvantages of the proposed transfer of the State Tuberculosis Sanatoria from the Maryland Tuberculosis Commission to the State Department of Health, the Executive Committee called a special meeting to consider this subject, to which were invited those with specific responsibilities or interests in this field. Those who attended the meeting were as follows:

Maurice C. Pincoffs, M.D., *Chairman*	Leroy Allen, M.D.
	Miriam Brailey, M.D.
Charles R. Austrian, M.D.	H. Warren Buckler, M.D.
Allen W. Freeman, M.D.	Walter N. Kirkman
Harry Greenstein	R. H. Riley, M.D.
Winford H. Smith, M.D.	G. Canby Robinson, M.D.
C. E. Wise, Jr.	Huntington Williams, M.D.

Very full discussion was held, and there was general agreement on the desirability of coordinating the State's tuberculosis work, and on the advantages which would accrue if the facilities for case finding, clinics for out-patient care and necessary laboratory facilities were combined under the same administration with the sanatoria. Placing of all these responsibilities under the State Department of Health has the manifest advantage that this State agency has its health officers and nurses already in every county of the State, as well as its regional laboratories, and is already actively engaged in the field of case detection, and prevention of tuberculosis.

At the close of the meeting the Chairman polled all those present, and there was unanimous approval of the transfer of the responsibility of administering the State sanatoria to the State Department of Health.

The Executive Committee was informed further that by formal action the Maryland Tuberculosis Commission had expressed its approval of the transfer and similar formal action of approval had been recorded by the State Board of Health.

At a meeting of the Committee on Medical Care on December 12, 1946, the above information and actions taken were presented. The Committee on Medical Care unanimously agreed to recommend to the State Planning Commission that the transfer be effected.

The Committee on Medical Care in its discussion of this subject considered the advisability of a thorough survey of the existing program for the control of tuberculosis in Maryland. It was the general consensus of the Committee that such a survey would be desirable, especially if its recommendation for the transfer of the sanatoria to the State Department of Health were adopted. The Chairman and the Executive Committee were authorized to explore the possibilities of obtaining funds from private sources to employ a recognized authority to conduct the proposed survey.

Out-Patient Mental Hygiene Service

Prior to the outbreak of war the Mental Hygiene Society of Maryland sponsored clinics held at irregular intervals in various Maryland counties. This experience indicated a widespread need for such service, as well as an increasing public demand. It was impossible to continue these clinics during the war, but after the cessation of hostilities the subject of organized provision of mental hygiene clinics throughout the State was taken up, and tentative agreement reached between representatives of the Mental Hygiene Society, the State Board of Health, and the Board of Mental Hygiene, that the administration of such clinics would most effectively be undertaken by the State Board of Health.

The Executive Committee, at a meeting on November 15, 1946, invited representatives of the organizations named above to present the details of the project. Those present were:

Maurice C. Pincoffs, M.D., *Chairman*	Walter N. Kirkman
	I. A. Pasarew
Charles R. Austrian, M.D.	George H. Preston, M.D.
J. D. Colman	R. H. Riley, M.D.
Harry Greenstein	Huntington Williams, M.D.
Winford H. Smith, M.D.	Walter D. Wise, M.D.
C. E. Wise, Jr.	Peregrine E. Wroth, M.D.

It was the consensus of the meeting that the State Board of Health, through its State-wide organization of county health officers and nurses, was the agency best qualified to administer a non-institutional mental hygiene service utilizing, for professional aspects of the work of the clinics, physicians designated by the Commissioner of Mental Hygiene, as well as those recommended by the Mental Hygiene Society of Maryland. On December 12, 1946, the Executive Committee presented these conclusions to the Committee on Medical Care, which agreed unanimously to recommend such a program to the State Planning Commission.

RECOMMENDATIONS

I.

In order to extend to Baltimore City the benefits of a State-supported medical care program analagous to that already in operation in the counties of Maryland, it is necessary that an agency for administering the City program be selected. The Health Department of Baltimore City is already engaged in a large program of preventive medicine involving the operation of many special clinics, visiting nurse service, laboratory service and a hospital for communicable diseases. These activities have brought it in close working relation with the practicing physician and the various medical institutions of the City. The success of a medical care program will depend upon the close integration of these existing facilities for preventive medicine with those to be provided for the care of the sick. It is the opinion of the Committee, therefore, that the Baltimore City Health Department is the logical governmental agency to be entrusted with the operation of the medical care program to be developed in the City of Baltimore. Therefore, the Committee on Medical Care recommends that:

It should be publicly recognized that the conservation of the health of the community and the individuals residing therein is officially the responsibility of the Baltimore City Health Department. In addition to the usual services of public health, which includes sanitation, the prevention of communicable diseases and positive health services in such fields as maternity and child hygiene, the Health Department should assume community leadership in the coordination of medical facilities in such a manner as will best serve the interests of the citizens of Baltimore City. In carrying out this recommendation there should be established in the City Health Department, at an early date, a Medical Care Section under the direction of a qualified medical administrator.

II.

Since the legislation providing for the medical care of the indigent and medically indigent in Maryland vests the administration of this program with the State Department of Health, it will be necessary, if the Baltimore City Health Department is to administer a similar medical care program in Baltimore City, to enact legislation permitting the transfer of funds. Therefore, the Committee on Medical Care recommends that:

Legislation be enacted necessary to permit the State Board of Health to transfer to the City of Baltimore such State funds as are available for the support of a medical care program to be administered by the Baltimore City Health Department.

III.

The medical care program outlined in the Interim Report of the Committee to Study the Medical Care Needs of Baltimore City (Appendix A to Exhibit A), which already has been studied and approved by some of the hospitals involved, by the Baltimore Hospital Conference, and by the medical profession, not only will offer to the indigent a more complete form of medical care than any heretofore available, but also will bring into working affiliation; practicing physicians, hospital out-patient departments, and the health department clinics. Thus, a most desirable coordination of medical resources will be achieved, which now is seriously lacking. The contacts and conferences between physicians engaged in general practice, those working in hospitals and those associated with the City Health Department will have a distinct educational value and tend thus to raise the level of medical care for the whole community.

Therefore, the Committee on Medical Care recommends that:

A program as outlined in Appendix A of the attached Exhibit A be adopted to meet the medical care needs of the recipients of public assistance in Baltimore City.

IV.

From a study of the experience of other States, and out of intimate acquaintance with the problem on the part of many of the committee members, has grown a strong feeling in the Committee that, if chronic disease hospitals are to function effectively as curative institutions rather than mere repositories for persons suffering from long-term illnesses, they must be closely affiliated with and immediately adjacent to general hospitals caring for the acutely ill. In addition, there are obvious economies in the avoidance of duplicated service, operating room, laboratory, x-ray and other specialized facilities, inherent in this proposal.

Therefore, the Committee on Medical Care recommends that:

The grounds of the Baltimore City Hospitals be selected as the site for the proposed State Chronic Disease Hospital to be erected in the Baltimore area, and that this chronic disease hospital be closely integrated as to medical staff and facilities with the Baltimore City Hospitals through appropriate cooperative administrative agreements.

V.

The State Board of Health is now responsible for a program of tuberculosis prevention, for case finding, for recording reported cases of tuberculosis, and for maintaining clinic facilities for ambulatory tuberculosis patients. It is considered that separate responsibility for the care of the tuberculosis patient; (1) during the hospital phase of his illness, and (2) during the longer period in which he lives in the community, is a handicap to an efficient program of tuberculosis prevention and control.

Therefore, the Committee on Medical Care recommends that:

The responsibility for the administration of the State tuberculosis sanatoria be transferred from the Maryland Tuberculosis Commission to the State Department of Health, and that the necessary legislation to effect this transfer, along with the necessary transfer of budget and fiscal responsibilities, be enacted.

VI.

Under the provisions of the Federal Hospital Survey and Construction Act, P. L. 725-US 1946, a single State agency must be designated to administer the construction phases of that Act, as provided for in Sections 621, 622, 623, 624 and 625 of that Act, and in accordance with the State plan developed under Sections 611 and 612 of that Act, now being carried on by the Hospital Survey Committee of the Maryland State Planning Commission. Inasmuch as the responsibility for hospital licensing now is vested with the State Department of Health, along with the responsibility for administering the State's chronic disease hospital program, it is felt that the State Board of Health is the logical agency in Maryland to charge with the responsibility of administering this program. This proposal is in accord with the action taken by the majority of other States and with the recommendations of the Council on State Governments.

Therefore, the Committee on Medical Care recommends that:

Legislation be enacted necessary to designate the State Board of Health as the agency to administer the construction phases of the program outlined in the Federal Hospital Survey and Construction Act, P. L. 725-US 1946; and further such legislation include the authorities necessary to comply with the various provisions of that Act.

VII.

The clear intent of the Federal Hospital Survey and Construction Act is that first consideration be given to non-urban needs. In Maryland this is particularly appropriate since many of the most urgent institutional needs are in the counties of Maryland. The Committee has no thought of urging the entrance by the State of Maryland into the field of providing hospital care for the acutely ill through the operation and ownership of institutions for this purpose. However, the Federal Hospital Survey and Construction Act provides that at least two-thirds of the cost of any project undertaken under the Act must be met from State, local, or private funds before Federal funds are available.

Therefore, it is likely that certain counties of Maryland, desirous of facilitating the erection of hospitals, will find themselves unable to participate in this program because of lack of authority to raise funds to match the Federal contribution. Since it is expected that Federal funds will shortly be available under this program, and since the Maryland State Legislature will not meet for at least one year, and possibly two, it is felt desirable that some authority be granted to counties and municipalities which would enable them to raise funds in order to participate in this program if they so desired.

It is proposed, however, that such legislative authority apply only to funds to be used for participating in a project properly authorized under the provisions of the Hospital Survey and Construction Act and in accordance with the State plan developed for Maryland for which Federal matching funds are available. This would avoid the objection that the authority contained in such legislation might be used to undertake uneconomic or over-expansive projects.

Therefore, the Committee on Medical Care recommends that:

Legislation be enacted authorizing counties and municipalities to issue bonds, or other evidences of indebtedness in excess of their present statutory debt limits, the proceeds from which can be used only to provide a portion or all of the non-federal share of funds for hospital construction authorized under P. L. 725-US 1946.

VIII.

The proposal that a hospital for the care of acute psychopathic disorders be erected in conjunction with the University Hospital in Baltimore has been widely approved. An appropriation sufficient for only a part of its cost now is available to the University of Maryland. A sub-committee of the Committee on Medical Care, appointed to review the construction program of the State Board of Mental Hygiene, recommended that the construction of this institution be given the highest possible priority in the State's post-war construction program. Such an institution would give needed stimulus to the training of physicians at the Medical School of the University of Maryland in the care

of mental disease. By providing facilities for teaching and research at a graduate level, it would elevate the quality of professional care available to patients in other State institutions for mental patients. To be fully effective, it is imperative that the medical, educational, and administrative policies of such an institution be closely integrated with those of the institutions administered by the State Board of Menal Hygiene.

Therefore, the Committee on Medical Care recommends that:

The additional funds necessary should be allocated for the construction of a hospital for the care of acute psychopathic patients as an addition to the present University Hospital in Baltimore; and that the construction of this project be given the highest possible priority and pressed to completion.

IX.

Late in 1944, a sub-committee of the Committee on Medical Care appointed to review the construction program proposed by the Board of Mental Hygiene for inclusion in the State's post-war construction program said: "The Committee wishes to point out that the State even now is far behind in its program of construction to meet the expanding needs for the care of the mentally ill. The normal increase in population and the concomitant increase in the number of persons requiring care for mental illnesses will not wait for a board to approve or a legislature to act. . . . The Committee is convinced that the program presented by the Board of Mental Hygiene is sound and by no means an excessive one. Indeed it may well be designated as a minimal program designed to meet only the immediate needs and absolutely essential to bring the provisions for care of the mentally ill up to the level where they should be if the State of Maryland is to discharge its obligations in a proper manner." In this view, the Committee on Medical Care wholly concurs. It also endorses the decision of the Board of Mental Hygiene to place first emphasis on the construction of adequate service facilities and housing for personnel so that the quality of care available even to the present patients in such institutions will be improved before any attempt is made to expand the number of patients cared for.

Therefore, the Committee on Medical Care recommends that:

The requests for funds now before the State Board of Public Works, or included in the budgets of the various State Mental Hospitals' 1947-1949 biennium, for operating purposes, for rehabilitation of plant, for construction of services and personnel housing, and for limited construction of new patients' facilities, be granted in their entirety.

X.

Certain Federal funds now are available for matching State and local funds in the support of non-institutional mental hygiene service. A service of this type would be very much akin to that now conducted by the State Board of Health in other fields of illness, such as tuberculosis, venereal disease, orthopedics, obstetrics, etc. Under existing Maryland legislation, the Board of Mental Hygiene is charged with the responsibility for the care of the mentally ill, and under the provisions governing the Federal funds it is likely that Maryland's share would necessarily go to the Board of Mental Hygiene, whereas this out-patient program might most logically be administered as a part of the present out-patient service of the State Board of Health.

Therefore, the Committee on Medical Care recommends that:

A division of mental hygiene be created in the State Department of Health; and further that legislation be enacted necessary to permit the State Board of Health to receive and expend Federal funds to be matched with local funds in the support of a mental hygiene service for out-patients, the professional phases of which are to be integrated as closely as possible with the professional programs of the State mental hospitals.

EXHIBIT A

INTERIM REPORT

to the

COMMITTEE ON MEDICAL CARE

of the

MARYLAND STATE PLANNING COMMISSION

from the

COMMITTEE TO STUDY THE MEDICAL CARE NEEDS OF BALTIMORE CITY

December, 1946

INTRODUCTION

At the request of the Medical and Chirurgical Faculty of Maryland, the Committee on Medical Care was established early in 1940 as a standing committee of the Maryland State Planning Commission. Because of the urgent problems of medical care in the counties of Maryland, the Committee turned its first attention to a study of these needs. A field survey of the medical facilities available in the counties was conducted during 1941. The analysis of these data, however, was delayed by the exigencies of the war. A "Report on Medical Care in the Counties of Maryland" was finally published by the Maryland State Planning Commission in April, 1944.

The principal recommendation called for the establishment of a program by the State of Maryland for the medical care of the indigent and the medically indigent. The report recommended that the formulation of the program and its administration should be the responsibility of the State Department of Health. In order to implement this recommendation, the report advocated that the State Board of Health be authorized to establish a Council of Medical Care to act in an advisory capacity and a Medical Care Section within the State Department of Health. The report further recommended that the county health officer should administer the local aspects of the medical care program in cooperation with the county medical societies.

In February, 1945 the General Assembly of Maryland passed a law authorizing the State Board of Health to establish a Bureau of Medical Services that should begin its work on July 1, 1945. The law provides that:

> "The Bureau of Medical Services, under the direction of the Director of Health, shall administer a program of medical care in the State of Maryland for indigent and medically indigent persons, or either of such classes; for the purpose the Bureau of Medical Services is hereby authorized to contract with physicians, dentists and hospitals for the medical, dental, surgical and hospital treatment of eligible persons; within the provisions of the budget the said Bureau is hereby authorized to provide bedside nursing care for eligible persons."

The program for the first two years under this legislation was limited to the counties of Maryland in accordance with the recommendation in the Report on Medical Care in the Counties of Maryland. The Committee on Medical Care in this report, however, recognized that a program should be developed to accomplish similar results in Baltimore City, but considered that such a program should be the subject of a separate inquiry and report by a local committee.

Organization of the Baltimore Committee

On August 5, 1944, Dr. Victor F. Cullen, Acting Chairman of the Committee on Medical Care, appointed the following Committee to study the medical care needs of Baltimore City:

Lowell J. Reed, Ph.D., *Chairman*	Thomas P. Sprunt, M.D.
George M. Anderson, D.D.S.	T. J. S. Waxter
Edwin L. Crosby, M.D.	Harvey H. Weiss
C. Reid Edwards, M.D.	H. Maceo Williams, M.D.
Herbert Fallin	Huntington Williams, M.D.
Frank J. Geraghty, M.D.	Samuel Wolman, M.D.
L. Edwin Goldman	W. H. Woody, M.D.

In a letter to the Chairman dated September 21, 1944, Dr. Cullen charged the committee as follows:

"It is the privilege and the responsibility of your Committee:

to take a broad view of the work of all these medical care resources of Baltimore;

to outline a pattern of relationship among them and to suggest any intensification or curtailment of the activities of any of them which will make their efforts most productive; and

to suggest the means for translating modern health and medical knowledge most fully into service available to citizens—both sick and well."

The first meeting of the Committee was held on September 27, 1944 and was devoted to a discussion of the objectives as stated in the above charge. The Committee agreed to review the activities of all the private, voluntary and governmental agencies which are connected with the problem of medical care, with a view to suggesting means for the integration of all these activities into a program of medical care as beneficial as possible to all the people of the city.

To enable the Committee to review these activities in a systematic manner, the chairman was authorized to organize a small staff to prepare the factual material required in the

committee's study of the problem. Dr. Huntington Williams, Commissioner of Health of Baltimore City, made available to the committee the services of Dr. W. Thurber Fales, Director of the Statistical section of the Baltimore City Health Department, to have charge of the collection and analysis of these data. Dr. Fales was also selected to serve as secretary of the Committee.

Outline of Subjects Reviewed by the Committee

During the last two years, the Committee has met at frequent intervals to study the material assembled by the working staff under the direction of the chairman. The wide range of subjects covered in this review is illustrated by the following outline that is modified but slightly from that presented at an early meeting of the Committee.

OUTLINE

A. Population
- Composition
  - Race, age, income, family size, geographic distribution
- Trends
  - Changing age composition, aging of the population, increase in Negro component

B. Estimates of illness
- Prevalence and incidence
- Distribution
  - Race, sex, age, income
- Causes of illness and disability
- Geographic distribution
- Source of data—Eastern Health District Studies
  - Other studies
- Selective Service examinations

C. Facilities for medical care
- Physicians
  - Number and distribution
  - General practitioners—specialists
  - Trend
- Dispensaries—out-patient departments
  - General and special
  - Public dispensaries of Department of Public Welfare
- Health Department clinics
  - Tuberculosis
  - Venereal disease
  - Prenatal
  - Well baby clinics
  - Immunization clinics
- Other Health clinics
  - Babies' Milk Fund Association
  - Industrial
- Hospitals
  - Public
    - Baltimore City Hospitals
    - Sydenham Hospital
  - Private
    - General
    - Special
- Auxiliary Facilities
  - Laboratories
    - Hospital
    - Health Department
    - Private
  - X-Ray
  - Other

D. Distribution of sickness load

E. Adequacy or inadequacy of facilities to meet needs

F. Financial problems involved
- Cost of services
- Individual aspects
- Institutional aspects
- Public participation
- Hospital and other forms of health insurance

G. Outstanding problems requiring special study
- Domiciliary and ambulatory care
  - Welfare clients
  - Population in general
- Dental care
- Convalescent care
  - Home
  - Institutional
- Hospitalization and home care of chronic ill
- Nursing homes
- Correction of remedial defects
- Rehabilitation

H. Possible solutions

The discussions of the Committee have followed this outline in a systematic fashion with the exception that the financial aspects of the problem have not as yet been studied in detail. Later deliberations of the Committee will deal more fully with this phase and also will cover more

completely those aspects of the problem that the committee has so far considered in only a general way.

The Committee is not prepared at the present time to submit a final report giving the detail evidence that has been collected around this outline and the conclusions that follow from this evidence. There are, however, several urgent issues that should be brought to the attention of the Committee on Medical Care of the State Planning Commission; hence this interim report.

Summary of Committee Discussions

As the Committee proceeded in the study of medical care in Baltimore City, the complexities of the problem stood out more and more clearly. It became apparent that the medical care program for an urban community like Baltimore City has many different facets. It could not confine itself to the physician's care of individual patients even though this included provisions for hospital care, dental care or nursing care.

The Committee's study of the distribution of illness revealed clearly that it is erroneous to consider the population as separated into two groups—the ill and the well. Health or its converse, illness, is a graded matter for every individual. In a very true sense it may be said that each person is ill to a certain degree and well to a certain degree. Thus the individuals in the population may be graded into ordered classes such as, essentially well, ill to a minor degree, more seriously ill, ill to the extent of calling for highly specialized services. A person's need for medical services depends upon his position within this classification and his passage from one category to another. Thus the problem of medical care involves a constant screening process that is carried out partially by the individual himself, partially by the physician, and partially by the various agencies and organizations that are concerned with maintaining or restoring health.

With the tremendous advances in the science of medicine, the interest of a larger and larger share of the medical profession is focused on illnesses that require special diagnostic and therapeutic facilities. A decreasing proportion of the time and energy of the medical profession is available for problems of medical care related to the treatment of minor illness and the maintenance of health. This lack of balance in medical effort is at variance with the objectives of a medical care program for a community, which are to maintain its population in health, to prevent minor illnesses from developing into major ones, and to restore to health as rapidly as possible those who have become ill.

To correct this we need to develop preventive services that will be integrated with our present diagnostic and therapeutic facilities. This calls for the creation of medical centers offering comprehensive medical care. Although such a program is not yet available to the population, much can be accomplished by a better coordination of the services offered by physicians, hospitals, clinics, the City Health Department and the many other public and private agencies.

That this is the case is well illustrated by the achievements in the fields of maternity, infant and child care where the Baltimore City Health Department, in cooperation with the physicians of the city, has provided better organization of medical services for both well and ill. This cooperation has expressed itself in such ways as; (1) the continuous campaign for diphtheria toxoid inoculation for infants, in which the physicians of the city play an important role by giving an ever-increasing proportion of the inoculations, and (2) the investigation of every maternal death and its subsequent review, at the monthly meeting of the Joint Health Department and City Medical Society's Committee on Maternal Deaths, for the purpose of determining which ones of these are preventable. These are but instances of a number of cooperative efforts that have led to a striking improvement of health and to a considerable conservation of life in the maternity and infancy groups.

Consideration of the needs previously expressed for more comprehensive medical services with an increased emphasis on preventive medicine, and realization of the accomplishments obtained in certain fields through cooperative efforts, led the Committee to its first major recommendation, which is as follows:

That the responsibility for coordination of all the *Health Services* for the population of the city should be publicly acknowledged as a proper function of the City Health Department. In carrying out this responsibility, the City Health Department should utilize the services of a qualified full-time medical administrative officer who will, under the Commissioner of Health, be responsible for planning and executing the program of a new Medical Care Section within the City Health Department.

Specific Problems

The Committee's study of the various factors influencing the problems of medical care in Baltimore revealed numerous shortcomings in specific facilities and programs. Many of these have been reviewed in the past and recommendations for remedial measures have been made. In some instances action has been taken to correct deficiencies, but

in recent years war conditions have delayed implementation of recommendations already accepted by governmental authorities. In order that certain deficiencies may receive immediate attention by the Committee on Medical Care and by the coming session of the General Assembly, recommendations on two specific problems are presented in this interim report.

Problem A—Chronic Disease Hospital for the Baltimore Area

The population of Baltimore is steadily aging. The proportion of the population over 45 years of age increased from 20.5 percent in 1910 to 26.5 percent in 1940. The relative increase in the population 65 years of age and over has been even greater, rising from 4.2 percent in 1910 to 6.8 percent in 1940. In the future the proportion of elderly persons will continue to increase.

A recent survey of illness in 1,500 families living in the Eastern Health District of Baltimore revealed that twenty percent of the population over 40 years of age suffers from chronic disease. Approximately three-fourths of the sick days for persons over 40 years of age in these families were due to chronic disease. The Committee found that these illnesses present one of the most pressing medical problems facing the community. Between 500 and 600 chronically ill persons are continually on waiting lists for hospital beds.

The last session of the General Assembly provided for the construction of three chronic disease hospitals in the State. The law provides that one should care for long-term patients from Baltimore City and the five counties—Anne Arundel, Baltimore, Carroll, Harford and Howard.

In discussing the location of these State Hospitals for Chronic Disease, the original report of the Governor's Commission on Chronic Diseases recommended that these institutions should be built in proximity to general hospitals, in order that the special facilities of such hospitals might be available to the chronic ill as required. The Committee's study of this problem led to the same conclusion, and the Committee has already submitted on January 7, 1946, to the Committee on Medical Care and the State Board of Health the following resolution on the location of the institution for the Baltimore area:

> "The Committee recommends that the Baltimore City Hospitals grounds be selected as a site for the chronic hospital for the Baltimore area and that the chronic hospital be closely integrated as to medical staff and facilities with the Baltimore City Hospitals through appropriate cooperative agreements."

The Committee reaffirms this resolution and incorporates it in this report as one of the items that needs immediate action. In taking this action, the Committee realizes that adequate provision for hospitalization for the chronic ill represents but one phase of the problem. The final report will contain the Committee's recommendations for handling other aspects of this growing problem.

Problem B—Medical Care of Indigent and Medically Indigent

The second pressing problem is one for which the State has recognized its responsibility and is one of the specific items which led to the appointment of the present Baltimore Committee. This problem is concerned with the provision for medical care to recipients of public assistance and other persons in low economic groups. As the Committee reviewed the medical services for these groups as now provided by the Department of Public Welfare of Baltimore City, it found many deficiencies that have developed because of the lack of any organized plan of medical service to individuals in these groups.

A program for providing medical care to corresponding groups in the counties of the State was inaugurated on July 1, 1945. While the program for a similar service in Baltimore City should be an extension of that already inaugurated in the counties, the pattern of service will be different in order that the greater medical facilities of the city may be utilized. The program, however, should be acceptable to the State Bureau of Medical Services and the State Council on Medical Care which are charged by law with the formulation of programs for such medical service throughout the State.

The Committee's third recommendation is that a specific plan be adopted to meet the medical care needs of the welfare population of Baltimore City. The essential elements of such a plan are presented in Appendix A. Although the suggested plan is directed at welfare clients, it is the belief of the Committee that it could be extended to pick up the problem of the medically indigent as soon as the service is sufficiently well organized to handle the load of individuals now on direct public assistance. The development and administration of the program should be the responsibility of the Commissioner of Health of Baltimore City, but would require the creation of a Medical Care Section in the Health Department for its specific administration.

RECOMMENDATIONS

In the present interim report, the Committee submits to the Committee on Medical Care of the State Planning Commission, the following three recommendations:

1. It should be publicly recognized that the conservation of the health of the Community and the individuals residing therein is officially the responsibility of the Baltimore City Health Department. In addition to the usual services of public health, which includes sanitation, the prevention of communicable diseases and positive health services in such fields as maternity and child hygiene, the Health Department should assume community leadership in the coordination of medical facilities in such a manner as will best serve the interests of the citizens of Baltimore City. In carrying out this recommendation there should be established in the City Health Department at an early date, a Medical Care Section under the direction of a qualified medical administrator.
2. The Committee recommends that the Baltimore City Hospitals grounds be selected as a site for the chronic hospital for the Baltimore area and that the chronic hospital be closely integrated as to medical staff and facilities with the Baltimore City Hospitals through appropriate cooperative agreements.
3. The Committee recommends the adoption of an organized plan for meeting the medical care needs of the recipients of public assistance. Such a program should meet emergency medical needs of this group and should also provide a comprehensive medical service for their long-term needs. The specific elements of such a plan are presented in Appendix A of this report.

APPENDIX A

A PLAN FOR ORGANIZED MEDICAL CARE FOR WELFARE CLIENTS RESIDING IN BALTIMORE CITY

FOREWORD

The following outline presents the essential elements of a plan for medical care of public assistance clients of Baltimore City. It has been prepared by the Committee to Study the Medical Care Needs of Baltimore City for submission to the Committee on Medical Care of the Maryland State Planning Commission. While it forms a part of an interim report to the State Committee on Medical Care, it will be included as an appropriate section of the final report of the Committee.

The ultimate objective is to provide for the welfare group in the city, continuous medical care comprising preventive, diagnostic, and therapeutic services, and such auxiliary services in the fields of dentistry, nursing, and rehabilitation as are feasible.

The program suggests the organization of medical centers associated with existing hospitals in order to provide a system of home and ambulatory medical care through the integration of the facilities of the hospital dispensary and the services of the physicians practicing in the area.

OUTLINE OF SPECIFIC PLAN

1. The planning and administration of medical care for welfare clients of the Department of Public Welfare of Baltimore City should be the responsibility of the Commissioner of Health of Baltimore City. For this purpose there should be created in the Baltimore City Health Department, a Medical Care Section. An Advisory Committee on Medical Care composed of representatives of participating professions and groups should be appointed by the Commissioner of Health to assist in the planning and to advise on administrative policy.

2. Each family or individual accepted for public assistance by the Department of Public Welfare of Baltimore City will be certified to the proposed Medical Care Section as eligible for medical care. The Department of Public Welfare will furnish the Medical Care Section with a statement as to the assistance classification of the client and such other information contained in the welfare records as may be required, to plan for appropriate medical care. The Medical Care Section will furnish the Department of Public Welfare upon request, reports of the physical status of public assistance clients assigned to it.

3. The Medical Care Section will formulate two plans of medical service; (a) a plan for emergency medical service for those clients of the Department of Public Welfare that are given only temporary public assistance, and (b) a plan for comprehensive medical service for those clients who will be given public assistance over a considerable period of time. The program for emergency medical care will be an extension of the current program to provide that physician services and hospitalization shall be available 24 hours of the day. The program for comprehensive medical service will be outlined below.

4. Each welfare client certified to the Medical Care Section will be assigned to plan (a) or (b) and will be instructed as to the medical services available to him. If his service is to be under plan (b), he will be instructed to register promptly at the medical center to which he is assigned by the Medical Care Section, even though he has no immediate medical care needs.

5. The Medical Care Section will sponsor in appropriate sections of the city, the organization of a number of medical centers. Insofar as practical, the medical center should be a part of the out-patient department of a hospital in the area. These centers will assume responsibility for home and ambulatory medical care for the families referred to it.

6. The medical center will appoint a competent medical administrator whose duty would be to organize and administer a program of comprehensive medical service for welfare clients assigned to the center. The medical facilities, services, and staff of each medical center participating in the program shall conform to certain minimum standards established by the Medical Care Section in consultation with its Advisory Committee on Medical Care.

7. In arranging for comprehensive medical service, the medical center will explain the nature of the program to the physicians practicing in the area and invite their cooperation in furnishing home and office care to welfare clients. The center will keep a register of physicians who express a willingness to participate in the medical care of these families.

8. The Medical Care Section will assign the welfare client to the medical center in accordance with the residence of the family. Upon registering at the medical center, the welfare client will be given specific information as to what he should do in case of illness in his family. If the welfare client has a family physician, he will be instructed to continue the physician's services. If the client has no physician, he should choose one from the list of participating physicians. In both instances the medical center will inform the selected physician of the client's registration with the medical center and ask the physician's cooperation in furnishing comprehensive medical service to the family. The medical center will be responsible for seeing that an adequate initial examination of the physical status of each welfare client is made and that the medical center and the client's physician have a copy of the findings of this examination.

9. The personal physician chosen by the welfare client will be the important keystone in furnishing medical service to this group. He should have general supervision of the health of those who select him. He will be expected to provide these families with those services that may be considered within the field of general practice. The physician will keep a record of all services rendered the client and periodically will furnish the center with a summary report. When the physician decides that the client requires diagnostic and therapeutic services not ordinarily provided by a general practitioner, he will refer the client to the medical center. He will consult with the center on any medical problems of the family while under his care. The center in every such instance shall furnish the physician with a complete report.

10. While the medical center may render medical care in emergency cases, it will ordinarily refer the patient to his physician for all care of a routine nature. The center will inform the client's physician of any medical service rendered at any time by the center. From time to time, the medical center will arrange for consultations and conferences with participating physicians relative to the program in general and the medical care needs of particular families and individuals.

11. The success of the program will depend upon the teamwork developed between the medical center and the participating physicians. In order to make such cooperation effective, each medical center will appoint an advisory committee composed of physicians selected from the staff of the center, the register of participating physicians, and of individuals representing other professional groups participating in the program. The committee will advise on the plans for organizing the services proposed and will develop through experience minimum standards for handling certain classes of cases. The committee will review from time to time the services of the medical center, the participating physicians and other professional personnel and make recommendations for improving the service.

12. The medical center and participating physicians shall utilize fully the preventive, special diagnostic, and nursing services of the Baltimore City Health Department. The bureau directors and district health officers of the Health Department will cooperate with the Medical Care Section in making these facilities available on a referral basis to the centers and to the participating physicians. The medical center will not be expected to develop for welfare clients, clinic services in such fields as venereal disease, tuberculosis, prenatal care, etc., which services are available through already established clinics of the Health Department.

13. When the physician finds that the condition of a welfare client requires hospitalization, he will notify the medical center which will then arrange with the Medical Care Section for hospitalization, under the program already in operation. The hospital will furnish the medical center and the physician with a report of the hospitalization that should include recommendation as to subsequent handling of the case.

14. A limited dental service for welfare clients will be organized by each medical center in order to provide for emergency dental service.

15. Such drugs as are required will be dispensed through the medical centers and retail druggists upon a participating physician's prescription. The policies for furnishing drugs should be determined by the Medical Care Section in cooperation with the local Advisory Committee on Medical Care. Biological products should be furnished the medical center and the participating physicians by the Laboratories of the Baltimore City Health Department in accordance with the current plan for general distribution of such products to the physicians of the city.

16. The principal financial support of the proposed plan for medical care of welfare clients should come from the State appropriation to the Bureau of Medical Services of the State Department of Health for providing medical service to the indigent and medically indigent of the State. Legislation should be secured at the next session of the Maryland Assembly authorizing the transfer of funds to the Mayor and City Council so that the plan may be administered by the Baltimore City Health Department.

Payment for services of the medical center will be based on the number of public assistance clients assigned to it. Payment to the participating physicians will follow the same principle and will be based on the number of clients selecting the physician for service. This capitation concept of payment is recommended by the Committee for several reasons, among which are (a) that this plan will permit greater freedom in the referral of any individual to his personal physician by the medical center, and by the physician to the center as the medical condition of the patient requires; and (b) that this plan simplifies the administration of the program and reduces to a minimum, the paper work that the general practitioner will be called upon to undertake.

The proposed tentative budget, which is based on an estimated load of 20,000 individuals on public assistance, covers the funds recommended for the operation of the plan for the first two years:

	1947-48	1948-49
Services of physicians	$150,000	$165,000
Services of medical centers	150,000	165,000
Emergency dental care	22,000	25,000
Drugs	40,000	48,000
Administration	14,000	15,000
Total	$376,000	$418,000

FLOW OF SERVICES UNDER THE PLAN

The accompanying diagram indicates the organization and flow of essential services as follows:

1. The family (client) applies to Department of Public Welfare for public assistance. If accepted, the welfare client is referred to the Medical Care Section for inclusion in the program of medical care.

2. The welfare client is referred to the medical center for comprehensive medical service. The Medical Care Section notifies the medical center of the client's eligibility for medical service under the plan.

3. The client registers with the medical center and selects a physician. The medical center sets up a record of medical services for each client.

4. The medical center then notifies the physician of his selection as personal physician for the client. After this, the welfare client will receive such home and ambulatory care as is required from the physician.

5. The physician of his choice refers the welfare client to the medical center for special diagnostic and therapeutic services.

6. The physician and medical center exchange records of all services rendered the client .

7. The medical center arranges for conferences and consultations with the physician concerning the medical care needs of the welfare client.

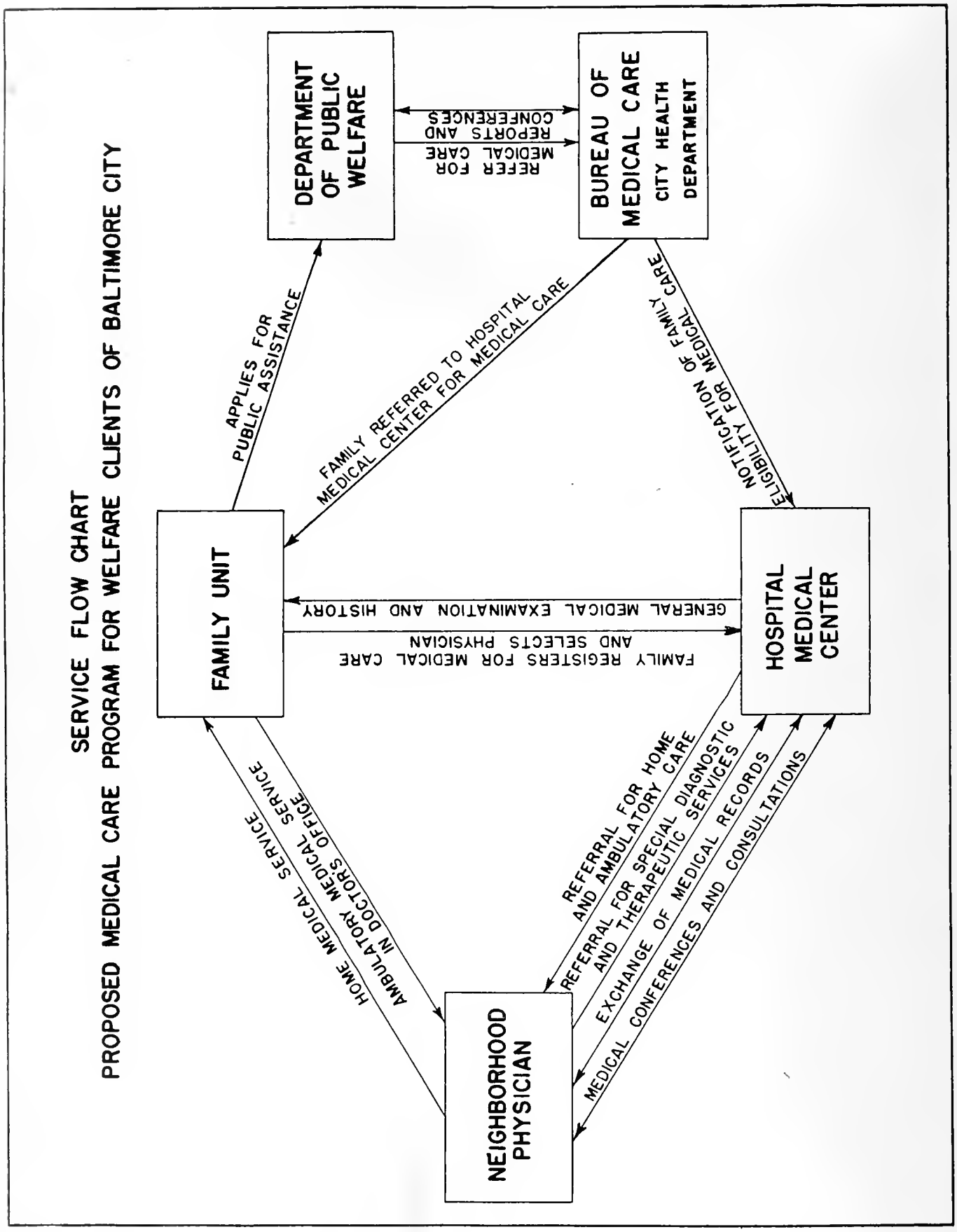
SERVICE FLOW CHART
PROPOSED MEDICAL CARE PROGRAM FOR WELFARE CLIENTS OF BALTIMORE CITY
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF MEDICAL CARE
CITY HEALTH DEPARTMENT
REFER FOR MEDICAL CARE
REPORTS AND CONFERENCES
APPLIES FOR PUBLIC ASSISTANCE
FAMILY REFERRED TO HOSPITAL MEDICAL CENTER FOR MEDICAL CARE
NOTIFICATION OF FAMILY ELIGIBILITY FOR MEDICAL CARE
FAMILY UNIT
HOSPITAL MEDICAL CENTER
GENERAL MEDICAL EXAMINATION AND HISTORY
FAMILY REGISTERS FOR MEDICAL CARE AND SELECTS PHYSICIAN
HOME MEDICAL SERVICE
AMBULATORY MED'L OFFICE SERVICE
REFERRAL FOR HOME AND AMBULATORY CARE
REFERRAL FOR SPECIAL DIAGNOSTIC AND THERAPEUTIC SERVICES
EXCHANGE OF MEDICAL RECORDS
MEDICAL CONFERENCES AND CONSULTATIONS
NEIGHBORHOOD PHYSICIAN

EXHIBIT B

SURVEY OF THE
HOSPITAL AND HEALTH FACILITIES
OF THE STATE OF MARYLAND

INTERIM REPORT

of the

HOSPITAL SURVEY SUB-COMMITTEE

of the

COMMITTEE ON MEDICAL CARE

of the

MARYLAND STATE PLANNING COMMISSION

December, 1946

MARYLAND STATE PLANNING COMMISSION
HOSPITAL SURVEY COMMITTEE

104 Equitable Building
Baltimore 2, Maryland

WILLIAM L. GALVIN
ROBERT M. REINDOLLAR
ROBERT H. RILEY
THOMAS B. SYMONS
HENRY P. IRR
Chairman

I. ALVIN PASAREW
Director

December 17, 1946

Maurice C. Pincoffs, M.D., Chairman
Committee on Medical Care
University Hospital
Redwood and Greene Streets
Baltimore 1, Maryland

Dear Dr. Pincoffs:

I take pleasure in transmitting herewith the first interim report of the Hospital Survey Committee for submission to the State Planning Commission.

Included is a history of the Hospital Survey Committee, its program, and a summary of the accomplishments to date, along with some recommendations for immediate action considered too important to be delayed until the work of the Committee is completed.

Yet to be done is the important work of studying the findings of the field survey and planning a long-range program for the expansion of hospital and clinical facilities to meet determined needs, as well as the preparation of a plan for the integration of these facilities. However, the recommendations made at this time are amply supported by the facts already available to the Committee.

When this Committee was appointed, it was intended that its work would comply with the requirements of Senate Bill 191 then pending in Congress and at the same time continue with the original work of the Committee on Medical Care which was "continuously to survey the problem of medical care for the citizens of the State."

With the passage of the Hospital Survey and Construction Act (Public Law 725) the State's Attorney General ruled that the State Planning Commission, in the light of existing statutes and the charge by the Governor, at the time of making funds available for the work of this Committee, was legally qualified and designated as the single State agency for the survey and planning work under the Act.

The Survey Committee has functioned, therefore, and will continue to function in the role of the Advisory Council to the State Planning Commission in this effort for the duration of the survey and planning as defined in the Act.

A composite report at the end of the Committee's work is contemplated, which will fully comply with the charge under which it was established. It is expected that the work will have been completed and the report ready for submission by June 30, 1947.

Sincerely yours,

Walter D. Wise

Walter D. Wise, M.D., *Chairman*
Hospital Survey Committee

FOREWORD

This interim report has been prepared at the request of the Committee on Medical Care and the State Planning Commission under whose auspices the Hospital Survey Committee was established.

Included is a history of the Hospital Survey Committee and its program and a summary of the work to date, along with some recommendations for action considered too important to be delayed until the work of the Committee is completed.

Yet to be done is the important work of studying the findings of the field survey and planning a long-range program for the expansion of hospital facilities to meet determined needs, as well as the preparation of a plan for the integration of these facilities. However, the recommendations made at this time are amply supported by the facts already available to the Committee.

A composite report at the end of the Committee's work is contemplated, which will fully comply with the charge under which the Committee was established.

THE FEDERAL HOSPITAL SURVEY AND CONSTRUCTION ACT

Congress passed the Hill-Burton Bill, known as Senate Bill 191, or the Hospital Survey and Construction Act, as one of the last acts of the 2nd Session of the 79th Congress. President Truman signed it on August 13, 1946, and it became known as Public Law 725.

Under the Law, the work is divided into two phases named in its title. The first phase is the survey and preparation of a plan. The second phase is the administration of the construction of facilities under the plan. The Law is so written that this work may be done as two separate efforts or as one continuous project. It is required that a "single State agency" be responsible for the survey and planning and that another "single State agency" be responsible for the administration of the construction. This may be the same agency.

For the State of Maryland, the present Hospital Survey Committee under its charge is limiting its work to the first phase of the Law and will complete its work with the preparation of a State plan. As a part of its final report, the Committee will recommend a State agency to be charged with the responsibility for the administration of the construction program.

The Law authorized the appropriation of $3,000,000 to be allotted to the States as grants to be expended for survey purposes in the amount of one-third of the total expenditures for such purposes by the States. It also authorized the appropriation of $75,000,000 annually for a period of five years for the construction of medical facilities. The grants are applicable to projects which are within the scope of the approved State plan and are based on one-third of the total costs of such projects. Funds were appropriated for the survey but, while authorized to be appropriated, no funds were appropriated for construction. It is assumed that this appropriation will be made by the new Congress when it convenes.

The funds to be appropriated will be allotted to the various States on the basis of a formula contained in the Law. On the basis of the formula, the State of Maryland is entitled to a sum of $46,158 for survey purposes and an annual allotment of $870,300 for a period of five years for construction.

If all of the funds available were utilized, it would be necessary that Maryland set up $92,316 for survey purposes, making a total of $138,474 available for this purpose. It is quite apparent that such sums are not necessary for the work of the present Committee; however, the State agency designated for the administration of the construction program will probably find it necessary to review the program from time to time and will no doubt utilize some of this money.

If all of the Federal construction funds available are utilized and if these funds are limited to the present amounts stipulated in the Law, the construction program will entail expenditures of $2,610,900 per year, or $13,054,500 for the five-year period.

It is required that each State wishing to participate in this program make formal application for such part of the Federal funds allotted to it as it may need for carrying out the purposes of the Act. The State Planning Commission, on October 24, 1946, filed with the United States Public Health Service such application, completed and accompanied by such documents as were required to establish the statutory authority for the State Planning Commission to function as the "single State agency" for the making of the survey and the preparation of the State plan. Correspondence with the United States Public Health Service relative to the details of the application indicate that, as of this date, the application is acceptable with the exception of the representation on the Survey Committee, which corresponds to the advisory council as required in the Law.

On November 25, 1946, Governor O'Conor appointed, as additional members of the Hospital Survey Committee, three persons nominated by the Committee for the purpose of broadening its representation. It is presumed that with these additions to the Committee, this single defect in the application will have been rectified and Federal funds will be forthcoming for the continuation of the work of the Committee.

Under the Law, the United States Public Health Service is required to prepare a set of general regulations to define the Law and implement its operations. A preliminary draft of these regulations has only recently become available. It is expected that when these regulations are finally set up, the work of the Committee will be more clearly defined and a more rapid approach to the final plan will be made.

Under the Law, certain bed maximums for the State are established in the various categories of medical facilities. Under the final regulations, hospital areas will be defined which will be classified on the basis of population content and graduated bed maximums will be established for the various types of areas.

The State plan is intended to make a determination of the differential between existing facilities and those established as needed. As a part of this plan, these needs will be established on a priority basis according to their urgency. The plan is also supposed to include a design for the integration of the various types of facilities between the areas so that adequate services may be established in or be available to every part of the State.

After the plan has been prepared, it is required that it be submitted to the Surgeon General for approval. Once having obtained the approval of the Surgeon General, the work of the Survey Committee will have been completed.

The administration of the construction phase of the program will then be undertaken by the "single State agency" given such authority. This agency may from time to time review the State plan for the purpose of adjusting it to changing conditions.

THE HOSPITAL SURVEY COMMITTEE

On November 2, 1945, the Executive Committee of the Committee on Medical Care of the State Planning Commission met at the Medical and Chirurgical Faculty Building for the express purpose of discussing the activities of the Commission on Hospital Care and the advisability of instituting a State-wide survey of hospital facilities.

The activities of the Commission on Hospital Care were reviewed. It was pointed out that the Commission was established to stimulate State-wide hospital surveys which, when completed in all States, would produce the first complete survey of hospital and public health facilities in the United States and, at the same time, would conform to the requirements of Senate Bill 191, then pending in Congress.

The contents of Senate Bill 191, as then written, were discussed and it was revealed that, under the provisions of the Bill, funds would be made available for surveys and hospital construction, but only to States having completed surveys and having prepared plans for the expansion of hospital and public health facilities where the needs were found to exist.

A resolution was then passed to the effect that the Executive Committee would advise the entire Committee on Medical Care of this development and secure authority from it to form and appoint a Hospital Survey Committee.

Dr. Victor F. Cullen, Acting Chairman of the Committee on Medical Care, addressed a letter to this group, as follows:

"In accordance with the responsibilities of the Committee on Medical Care of the Maryland State Planning Commission, 'to keep under constant survey the problems of medical care for the citizens of this State, and to formulate recommendations for better utilization and for extension of existing facilities and for the institution of such new facilities as are required,' and in view of the physical additions presently contemplated by many of our Maryland hospitals, the establishment of a Hospital Survey Committee has been considered imperative. The following persons have been selected as members of the Committee:

J. Douglas Colman	Huntington Williams, M.D.
W. D. Noble, M.D.	C. E. Wise, Jr.
George H. Preston, M.D.	Walter D. Wise, M.D.
Robert H. Riley, M.D.	Benjamin W. Wright
Winford H. Smith, M.D.	Peregrine E. Wroth, M.D.
Harvey B. Stone, M.D.	Ralph Young, M.D.

"The Committee shall elect its own chairman.

"Hospitals do not achieve their fullest usefulness if their interests are limited to their primary function of restoring to health those disabled by illness or injury. In addition, hospitals have opportunities to maintain and improve health; to provide educational opportunities and encouragement for the members of the medical, dental, nursing and allied professions; contribute to the advancements of science through research; and to serve more actively in the education of the public in matters pertaining to the maintenance of health. Therefore, the functions of the Committee are:

1. To survey existing institutional facilities for the care of the sick and for the rendering of public health service.

2. To analyze the facts governing the availability and use of these facilities.

3. To define the need for additional facilities.

4. To develop a long-range program whereby existing facilities and such additional facilities as are recommended may operate to provide a comprehensive and integrated hospital service for the citizens of Maryland.

"In performing its function, the Committee should recognize the provisions of the several contemplated federal public works programs, under which, funds may be available for hospital construction. It is imperative that the work of this Committee should be pursued with all

possible dispatch and upon its completion, a report of its findings and recommendations presented to the Committee on Medical Care of the Maryland State Planning Commission. Any interim reports which may seem indicated will, of course, be welcomed.

"Through the interests of Governor Herbert R. O'Conor, funds have been made available to the State Planning Commission, which should provide for the technical assistance necessary for the Committee effectively to perform its functions."

At a meeting held Friday, February 22, 1946, Dr. Walter D. Wise was unanimously elected Chairman of the Committee.

The Hospital Survey Committee, at the outset, recognized in its assignment three definable phases and several limiting factors. The initial phase would be the taking of an inventory of the existing medical facilities. The second stage of the work would entail the compilation of the data thus gathered and an analysis of these facilities quantitatively, qualitatively, geographically, and in relation to population trends. The third phase would consist of the establishment of the actual need for the various types of facilities, a determination of the differential between existing facilities and those considered adequate to meet the need, and the preparation of a long-range plan for the installation of the facilities required to meet the established need, giving special consideration to the urgency of the need from the standpoint of type of service and location.

The limiting factors were funds and time.

The fund of $8,500 made available by the Board of Public Works was sufficient for the employment of only a small staff and for the payment of only minimum incidental expenses.

The time element imposed a need for expeditious action. There was a generally recognized immediate need for additional medical facilities in all categories. The Hospital Survey and Construction Act, then pending in Congress, contained clauses stipulating that grants would be made for hospital construction, but required that a State plan for such expansions must have been completed and approved by the Surgeon General before funds for construction could be released. The limited personnel which could be employed with the modest appropriation for this purpose would be required to work with dispatch to complete the work before the survey funds were exhausted.

At its meeting April 16, 1946, the Survey Committee adopted a working program, as follows:

1. Use the Hospital Schedule of Information to cover hospitals, and Public Health Department Facilities Schedule of Information to cover public health facilities. Both of these forms were prepared by and are available through the Commission on Hospital Care.
2. Have schedules completed by the local health officers and hospital administrators.
3. The health officers should return their forms when completed, but the administrators should hold theirs until representatives of this Committee had audited them.
4. One copy of the completed schedules would be held for study and the other submitted to the Commission on Hospital Care for tabulation. The Commission should return this copy along with a set of punch cards when the tabulations are complete.
5. One copy of the Hospital Schedules will be returned to the administrators.
6. At the completion of the work, the files, including the schedules, with the deletion of Section G, entitled Financial Data, will be turned over to the State Department of Health.
7. Since the Bureau of Medical Services of the State Department of Health is seeking the same information as the basis for licensing medical institutions, cooperation should be accepted from and given to this Bureau.

For the purpose of giving the Committee broader representation and in order to have the benefit of their own thinking and the thinking of the groups they represent, the following were nominated for membership on the Survey Committee:

Dr. Ernest L. Stebbins, Director of the School of Hygiene and Public Health of The Johns Hopkins University.

Mr. J. David Cordle, Secretary-Treasurer of the Brotherhood of Railway Clerks of the Baltimore and Ohio Railroad.

Mr. Edward T. Young, Jr., City Editor of The Evening Sun.

These nominations were presented to the Committee on Medical Care for approval. On November 25, 1946, the Governor announced the appointments, thus bringing the membership of the Committee to sixteen.

THE FIELD SURVEY

Hospitals of All Types and Nursing Homes

The field survey was undertaken for the purpose of compiling data as to the total number of medical institutions, beds and ancillary departments and public health facilities available in the State.

The first work to be done was the compilation of a complete list of all institutions in the State maintaining facilities for the care of patients. This was simplified by reason of the fact that the Legislature had enacted a hospital licensing law in 1945 (Annotated Code of Maryland 1939, Sections 496A to 496K), and the Bureau of Medical Services of the State Department of Health had already compiled such a list. A copy of the list was supplied to the survey office.

Since the Bureau of Medical Services had planned to use for its basic files on the licensed institutions data similar to that required for the completion of the Schedules of Information to be used in the survey, the survey work was complementary to the field work necessary for State licensing purposes. The Bureau of Medical Services, in line with its work of inspecting prior to licensing hospitals, made its facilities and personnel available to assist with the survey work. The hospital consultant of that Bureau, at the time of inspecting institutions for licensing purposes, on numerous occasions, completed the survey Schedule of Information on the institution. This cooperation was very valuable to the survey throughout the period of the field work.

Additions and deletions were made to the list as new institutions were found and others discontinued in service. These changes were almost entirely in the category of nursing homes.

The original list, along with additions made during the period of the field work, included 231 institutions. Of those listed, 31 had either not followed through with their plans to open or had closed. The balance of 200 institutions were included in the survey. (Table A.)

Table B is a tabulation of the institutions by type of ownership and by counties.

Every institution on the list was mailed two copies of the Schedule of Information. These schedules contained forty pages of questions, covering the following headings:

A. General Data
B. Area Served
C. Physical Plant
D. Patient Service Data
E. Medical Staff
F. Administration
G. Financial Data
H. Educational Activities
J. Research Activities

The recipients of these schedules were requested to complete them and keep them available pending the visit of a field worker. Because of the comprehensiveness of the schedules and the recognized difficulty in preparing the statistics requested for their completion at a time when most medical institutions were very busy and experiencing personnel shortages, a period of thirty days was allowed to

MEDICAL INSTITUTIONS IN THE STATE OF MARYLAND

TABLE A

County	Original Totals	Deleted Due to Closing, Etc.	Included in Survey
Allegany	9	—	9
Anne Arundel	5	1	4
Baltimore	29	4	25
Baltimore City	81	9	72
Calvert	1	—	1
Caroline	1	—	1
Carroll	9	2	7
Cecil	6	3	3
Charles	1	—	1
Dorchester	4	—	4
Frederick	8	—	8
Garrett	1	—	1
Harford	4	1	3
Howard	2	—	2
Kent	3	—	3
Montgomery	30	6	24
Prince George's	7	—	7
Queen Anne's	4	—	4
St. Mary's	1	—	1
Somerset	1	—	1
Talbot	7	2	5
Washington	9	—	9
Wicomico	8	3	5
Worcester	—	—	—
Total	231	31	200
Infirmaries in Jails, etc.	4	4	—
Grand Total	235	35	200

INSTITUTIONS BY TYPE OF OWNERSHIP OR CONTROL AND BY COUNTIES

TABLE B

County	Governmental*				Non-Governmental			Totals
	State	City	County	City-County	Non-Profit		Proprietary	
					Church	Non-Profit		
Allegany	1	—	2	1	1	—	4	9
Anne Arundel	1	—	—	—	—	1	2	4
Baltimore City	1	2	—	—	16	21	32	72
Baltimore County	3	—	—	—	3	5	14	25
Calvert	—	—	—	—	—	1	—	1
Caroline	—	—	—	—	—	—	1	1
Carroll	2	—	—	—	1	—	4	7
Cecil	—	—	—	—	—	1	2	3
Charles	—	—	—	—	—	1	—	1
Dorchester	1	—	—	—	—	1	2	4
Frederick	1	—	2	—	—	3	2	8
Garrett	—	—	—	—	—	—	1	1
Harford	—	—	—	—	—	1	2	3
Howard	—	—	—	—	—	—	2	2
Kent	—	—	—	—	—	1	2	3
Montgomery	—	—	—	—	2	3	19	24
Prince George's	—	—	—	—	1	1	5	7
Queen Anne's	—	—	—	—	—	—	4	4
St. Mary's	—	—	—	—	—	1	—	1
Somerset	—	—	—	—	—	1	—	1
Talbot	—	—	—	—	—	2	3	5
Washington	—	—	1	—	2	2	4	9
Wicomico	1	—	—	—	—	2	2	5
Worcester	—	—	—	—	—	—	—	—
Totals	11	2	5	1	26	48	107	200

* No Federal institutions included.

elapse between the mailing of the schedules and the visit of the field worker.

Preceding the mailing of the schedules, a letter was sent by Dr. Merrill L. Stout, Director of the Hospital for the Women of Maryland, who was President of the Maryland-District of Columbia Hospital Association. This letter portrayed the survey as something apart from the usual questionnaire, so many of which hospital administrators receive.

Accompanying the Hospital Schedules at the time of mailing was a letter from Dr. Walter D. Wise, Chairman of the Hospital Survey Committee, requesting that the information be entered promptly in preparation for the later visit by the field worker.

Visits were made to all of the 200 institutions and to some of those which were later deleted from the list when they were found to have discontinued their work.

The administrators of the institutions, with few exceptions, were willing to cooperate with the survey effort but were universally seriously handicapped due to shortages of personnel and excessive utilization of their institutions and other current problems. A number of administrators made such comments as, "Problems are greater now than during the war"; or, "This is the most difficult year ever experienced."

In only a very small number of institutions was the schedule completed at the time of the field worker's visit. In some cases, even though the notice had been sent of the planned visit, there had not been a single entry made prior to the arrival of the field worker.

Some schedules, especially in the cases of nursing homes, were completed by the field worker from the meager records available. In the larger institutions, where considerable time was required to prepare the statistical data, the administrator was assisted with the factual data and urged to complete the balance of the work by the time of a later visit. Many institutions had to be visited more than once and, in some cases, as many as four repeated visits were necessary before the schedule was completed and ready for audit.

The individualism of medical institutions was effectively demonstrated in the effort to reduce the statistics of their work and the functioning of their departments to a uniform set of questions. On frequent occasions, the ambiguous answers "Yes and No" had to be reduced to a "Yes" or "No."

By a gradual process, the number of completed schedules in the office increased and the unfinished list decreased. On September 8, 108 completed Hospital Schedules were shipped to the Commission on Hospital Care for tabulation and the preparation of punch cards. By the end of October, the field work was completed, there remaining out only a few schedules which had been audited and were in the process of being typed by the institutions.

Public Health Facilities

Schedules of Information covering Public Health Department facilities were sent to the health officers in each of the counties and the City of Baltimore. Dr. Robert H. Riley, Director of the State Department of Health, and Dr. Huntington Williams, Commissioner of the Baltimore City Department of Health, urged their respective staffs to complete and return these schedules promptly.

The responsible persons, in each county and in each district in the City of Baltimore, performed this duty and returned the schedules completed, with the result that this phase of the survey was completed with a minimum of effort on the part of the survey staff.

The field work was started early in April and completed by the end of October.

Classification of Institutions

The Hospital Survey and Construction Act was intended to include General Hospitals, Tuberculosis Sanatoria, Mental Hospitals, Chronic Disease Hospitals, and Public Health Facilities. The survey, because of the State Chronic Disease Hospital Program, included in addition; nursing homes, homes for the aged, and other special types of institutions. This was done for the purpose of gathering data on the number of patients being cared for in places other than their homes, and determining the potential load which would fall on institutions of the various types once they became available.

Because of the inclusive nature of the survey, it was necessary to group the types of institutions under twelve headings. The original grouping included the following categories:

1. General
2. Nervous and Mental
3. Tuberculosis
4. Contagious
5. Obstetrics
6. Pediatrics
7. Orthopedics
8. Eye, Ear, Nose and Throat
9. Convalescent
10. Skin and Cancer
11. Chronic
12. Others, including aged

In Table C they are shown by categories and by county.

The institutions were requested to report their bed complement, which is the "number of beds actually set up and in use for in-patients, excluding bassinets for newborn infants." They were also asked to report their normal bed capacity, which is "the number of beds for which the institution was designed or, in lieu of this information, the number of beds which could be set up allowing 80 square feet of floor space per bed." The differential between the bed complement and the normal bed capacity is indicative of the expansion of capacity or crowding which the institution had permitted without adding space for beds.

The original tabulation of the bed complement by counties and by type of institution is shown in Table D.

After the bed complement for the State by counties and by type of service had been completed, it became necessary to group them under the four main headings referred to in the Hospital Survey and Construction Act; that is, General Hospitals, Tuberculosis Sanatoria, Mental Hospitals, and Chronic Disease Hospitals. The Act specifically excludes institutions giving only domiciliary care.

In the first grouping, before the institutions which give only domiciliary care and others which it was felt fall outside the scope of the Act were set aside, the twelve categories were reclassified under four main headings of the Act. General hospitals included those institutions caring for acutely ill medical and surgical patients. Hospitals admitting patients having conditions which fall in the category known as the specialties were grouped separately. In this group were contagious disease, obstetrical, pediatric, orthopedic; and eye, ear, nose and throat hos-

INSTITUTIONS BY TYPE OF SERVICE

TABLE C

COUNTY	General	Nervous and Mental	Tuberculosis	Contagious	Obstetric	Pediatric	Orthopedic	Eye, Ear Nose and Throat	Convalescent	Skin and Cancer	Chronic	Others, Including Aged	Totals
Allegany	3	1	—	—	1	—	—	1	—	—	3	—	9
Anne Arundel	1	1	—	—	1	—	—	—	—	—	1	—	4
Baltimore	—	9	3	—	—	—	—	—	5	—	5	3	25
Baltimore City	18	2	—	1	1	—	2	2	16	1	23	6	72
Calvert	1	—	—	—	—	—	—	—	—	—	—	—	1
Caroline	—	—	—	—	1	—	—	—	—	—	—	—	1
Carroll	—	1	1	—	—	—	—	—	2	—	—	3	7
Cecil	1	—	—	—	1	—	—	—	—	—	1	—	3
Charles	1	—	—	—	—	—	—	—	—	—	—	1	1
Dorchester	1	1	—	—	—	—	—	—	—	—	—	2	4
Frederick	3	1	1	—	—	—	—	—	—	—	—	3	8
Garrett	—	—	—	—	—	—	—	—	—	—	1	—	1
Harford	2	—	—	—	—	—	—	—	1	—	—	—	3
Howard	—	2	—	—	—	—	—	—	—	—	—	—	2
Kent	1	—	—	—	—	—	—	—	—	—	2	—	3
Montgomery	3	2	—	—	—	—	—	—	12	—	7	—	24
Prince Goerge's	3	2	—	—	—	—	—	—	—	—	—	2	7
Queen Anne's	—	—	—	—	—	—	—	—	—	—	4	—	4
St. Mary's	1	—	—	—	—	—	—	—	—	—	—	—	1
Somerset	1	—	—	—	—	—	—	—	—	—	—	—	1
Talbot	1	—	—	—	2	—	—	—	—	—	—	2	5
Washington	1	—	—	—	1	—	—	1	2	—	3	1	9
Wicomico	1	—	1	—	—	—	—	—	2	—	—	1	5
Worcester	—	—	—	—	—	—	—	—	—	—	—	—	—
Totals	43	22	6	1	8	—	2	4	40	1	50	23	200

pitals. Mental hospitals included primarily those for the care of the mentally ill. Tuberculosis sanatoria included those institutions where admissions are limited to patients having tuberculosis. One hundred beds maintained at Springfield State Hospital for the care of mental patients having tuberculosis were counted as beds for mental patients. Chronic disease hospitals included nursing homes, institutions for the care of convalescent patients, chronics, incurables, and aged.

The inclusive totals under the four broad headings are shown in Table E.

More detailed analyses of the institutions and their constituent departments were made to determine which institutions should be excluded from the survey and which categories would be credited with certain groups of beds.

Under general hospitals during the period of the survey, the Schnauffers Hospital at Brunswick in Frederick County had closed, taking 30 beds out of the total.

The Leland Memorial Hospital had included in its report 21 beds which are in a separate building and are used entirely for chronics and aged.

Johns Hopkins Hospital had included in its total 87 beds in the Phipps Psychiatric Clinic which beds, it was decided, should be credited to the mental hospital bed total.

The Baltimore City Hospitals had included 280 beds for tuberculosis patients, 451 beds for chronics, and 705 beds for ambulatory aged, all of which were removed from the general hospital bed total.

From the category of mental hospitals, it was considered proper to exclude Rosewood State Training School for feeble-minded. It has reported 1,386 beds. Also excluded were the Bowditch Hospital School, with 24 beds; the Silver Cross Home, with 21 beds, both institutions for epileptics; and the Marine Home for Retarded Children, with a bed complement of 12.

There were no deletions from the number of beds available for tuberculosis patients; however, the 280 beds for tuberculosis patients at the Baltimore City Hospitals were added.

The groups included in the category giving care to chronics, convalescents, aged and others, ranged all the way from institutions bordering on the luxurious to places operated under conditions not fit for human habitation. In the final analysis this group should be sharply dis-

BEDS BY TYPE OF INSTITUTION
BY COUNTIES AND BY TYPE OF PATIENT
TABLE D

County	General		Nervous and Mental		T.B.		Contagious Disease		Obstetrics		Pediatrics		Orthopedics		Eye, Ear, Nose and Throat		Convalescent		Skin and Cancer		Chronic		Others, Including Aged		Total		Grand Total	Number of Institutions
	W	NW	W	NW	W	NW	W	NW	W	NW	W	NW	W	NW	W	NW	W	NW	W	NW	W	NW	W	NW	W	NW		
Allegany	391	2	96						6						17						48				558	2	560	9
Anne Arundel	70			1234						3											9				79	1237	1316	4
Baltimore			4112		453	11											126				89		182		4962	11	4973	25
Calvert	15	11																							15	11	26	1
Caroline									8																8		8	1
Carroll			3011			357											11						37		3059	357	3416	7
Cecil	62	10							4												13				79	10	89	3
Charles	23	8																							23	8	31	1
Dorchester	57	18	492																				22		571	18	589	4
Frederick	175	33	30		523																		234	22	962	55	1017	8
Garrett																					24				24		24	1
Harford	78	11															20								98	11	109	3
Howard			51																						51		51	2
Kent	25	6																			13				38	6	44	3
Montgomery	323	20	100														141				141				705	20	725	24
Prince George's	206		97																				114		417		417	7
Queen Anne's																					31				31		31	4
St. Mary's	35	10																							35	10	45	1
Somerset	30	8																							30	8	38	1
Talbot	83	25							8	6													26		117	31	148	5
Washington	185								4						26		54				54		22		345		345	9
Wicomico	147	30			60												39						64		310	30	340	5
Worcester																											0	0
County—Total, White	1905		7989		1036				30						43		391				422		701		12517		14342	128
County—Total, Negro		192		1234		368				9														22		1825		
Baltimore City	5730	514	425				100		8				172	47	79	26	343		21		884	18	566	32	8328	637	8965	72
State—Total, White	7635		8414		1036		100		38				172		122		734		21		1306		1267		20845			
State—Total, Negro		706		1234		368				9				47		26						18		54		2462		
																											23307	200

GROUPED INSTITUTIONAL BED COMPLEMENT
FROM ORIGINAL CLASSIFICATION
TABLE E

Type of Institution	Number of Institutions	Bed Complement
General Hospitals	43	8,341
Tuberculosis Sanatoria	6	1,404
Mental Hospitals	22	9,648
Including institutions limiting admissions to:		
Epileptics		
Feeble-Minded		
Mental		
Special Hospitals	15	514
Including institutions limiting admissions to:		
Contagious 1		
Obstetrical 8		
Orthopedic 2		
E. E. N. & T. 4		
Chronic Hospitals	114	3,400
Including institutions limiting admissions to:		
Chronics 90		
Convalescents		
Aged and Others 24		
Totals	200	23,307

counted because few of them offer more than domiciliary care and such institutions were supposed to be excluded from the survey. However, for the immediate purposes of the study, it was determined to remove from this group those institutions caring only for aged persons and those giving only domiciliary care.

The results of this reclassification of institutions and departments within institutions are shown on Table F.

The normal bed capacities were determined from the reports and are also shown on Table F.

An analysis of normal bed capacities by type of ownership, type of hospital, and assignment by race is shown on Table G.

Having established the net normal bed capacities, comparisons were made with the maximum for each category as set up in the Hospital Survey and Construction Act.

The standards in Public Law 725 are:

General hospital beds	4.5 per 1000 population
Mental hospital beds	5.0 per 1000 population
Tuberculosis sanatoria beds	2.5 times the average annual deaths from tuberculosis in the State over the 5-year period from 1940 to 1944*
Chronic disease hospital beds	2.0 per 1000 population

* Deaths from tuberculosis in the State of Maryland from 1940 to 1944, inclusive were: 1940—1,302; 1941—1,256; 1942—1,263; 1943—1,250; 1944—1,285.

RECAPITULATION OF BEDS AND INSTITUTIONS
AFTER RECLASSIFICATION
TABLE F

Type of Institution	Number of Institutions	Bed Complement	Normal Bed Capacities	*Standard Under P. L. 725	Differential Between Normal and Standard in P. L. 725
General	42	6,874	6,566	8,923	—2,357
Special	7	300	300	—	+300
Tuberculosis	6	1,684	1,883	3,177	—1,294
Mental	18	8,292	7,453	9,915	—2,462
Chronic	89	2,391	2,391	3,966	—1,575
Totals	162	19,541	18,593	25,981	—7,388

* Population estimate 11/1/43—1,982,947 (U. S. Bureau of Census—Series P-46, No. 3).

Using the population data prepared by the United States Census Bureau from Ration Book registration as of November 1, 1943, which shows the population for Maryland as 1,982,947, the following standards were set up:

General hospital beds	8,923
Mental hospital beds	9,915
Tuberculosis sanatoria beds	3,177
Chronic disease hospital beds	3,966
Total	25,981

The 1943 census estimate was used for illustration. The census base for application of Public Law 725 will be prescribed by Federal regulation.

The standards in each of the categories were compared with the existing normal bed capacities in Table F, showing the following resultant differentials:

	Standards per Public Law 725	Existing Normal Count	Deficiencies
General hospital beds	8,923	6,566	—2,357
Mental hospital beds	9,915	7,453	—2,462
Tuberculosis sanatoria beds	3,177	1,883	—1,294
Chronic disease hospital beds	3,966	2,391	—1,575
Beds in special hospitals		300	300
Totals	25,981	18,593	—7,388

It was found that the over-all shortage of beds in all categories, when compared with the standards set up in the Act, was 7,388. Detailed tabulations of the four categories are shown in Tables H, I, J, K, and L.

NORMAL BED CAPACITIES

BY TYPE OF OWNERSHIP, TYPE OF HOSPITAL AND BED ASSIGNMENT BY RACE

TABLE G

County	General												Mental								Tuberculosis						Voluntary		Special			Chronic	
	State		County[1] and/or City[2]		Voluntary		Proprietary		State		County[1] and/or City[2]		Voluntary		Proprietary		State		County[1] and/or City[2]		Voluntary		Voluntary		Proprietary		Proprietary	
	W	NW	W	NW	W	NW	W	NW	W	NW	W	NW	W	NW	W	NW	W	NW	W	NW	W	NW	W	NW	W	NW	W	NW	W	NW	W	NW
Allegany	49	2	218[1&2]	x	124	x					52[1]	x																	17		15	
Anne Arundel					58	12				1044																					9	
Baltimore									2013				238		99		199	11			254										206	
Calvert					15	11																										
Caroline																																
Carroll									2688									538													21	
Cecil					62	10																									13	
Charles					25	8																										
Dorchester					47	18			466																						3	
Frederick			33[1]	22[1]	100	11									55		523															
Garrett																															24	
Harford					61	11	17																								20	
Howard															51																	
Kent					25	a									100																13	
Montgomery					310	20																									135	
Prince George's			102[1]	x			104								85																31	
Queen Anne's																															31	
St. Mary's					35	10																										
Somerset					30	8																										
Talbot					67	20																										
Washington					132	10																							26		76	
Wicomico					147	30											78														39	
Worcester																																
County Totals	49	2	353	22	1238	179	121		5167	1044	52	x	238		390		800	549			254								43		696	
Baltimore City	354	81	100[2]	x	3650	417							483		79				280[1]	x									216	41	1695	
State Totals	403	83	453	22	4888	596	121		5167	1044	52	x	721		469		800	549	280	x	254								259	41	2391	
City and County Total	453	22							52								280															
Voluntary Total	4888	596							721								254															
Proprietary Total	121								469																							
Total for Category	5865	701							6409								1334	549											259	41	2391	
Non-white Beds	701								1044								549												41			
Combined White and Non-white Bed									7453								1883												300		2391	
Total for General Category	6566																															
Mental	7453																															
Tuberculosis	1883																															
Special	300																															
Chronic	2391																															
Grand Total	18593																															

a Have 6 extra beds set up for negro patients. x No racial segregation.

GENERAL HOSPITALS

BED COMPLEMENT, NORMAL BED CAPACITY, AND BED ASSIGNMENT BY RACE

TABLE H

Name of Hospital	Location	Complement			Normal		
		White	Non-white	Total	White	Non-white	Total
	ALLEGANY COUNTY:						
Allegany Hospital	Cumberland	124	*	124	124	*	124
Memorial Hospital	Cumberland	218	*	218	218	*	218
Miners Hospital	Frostburg	49	2	51	49	2	51
	ANNE ARUNDEL COUNTY:						
Annapolis Emergency Hospital	Annapolis	58	12	70	58	12	70
	CALVERT COUNTY:						
Calvert County Hospital	Prince Frederick	15	11	26	15	11	26
	CECIL COUNTY:						
Union Hospital	Elkton	62	10	72	62	10	72
	CHARLES COUNTY:						
Physicians Memorial Hospital	La Plata	23	8	31	25	8	33
	DORCHESTER COUNTY:						
Cambridge-Maryland Hospital	Cambridge	57	18	75	47	18	65
	FREDERICK COUNTY:						
Frederick City Hospital	Frederick	114	11	125	100	11	111
Frederick County Emergency Hospital	Frederick	31	22	53	33	22	55
	HARFORD COUNTY:						
Fountain Greeo Hospital	Bel Air	17	—	17	17	—	17
Harford Memorial Hospital	Havre de Grace	61	11	72	61	11	72
	KENT COUNTY:						
Kent and Queen Anne's General Hospital	Chestertown	25	6	31	25	—	25
	MONTGOMERY COUNTY:						
Montgomery County General Hospital	Olney	30	10	40	30	10	40
Suburban Hospital	Bethesda	92	10	102	92	10	102
Washington Sanitorium and Hospital	Takoma Park	201	—	201	188	—	188
	PRINCE GEORGE'S COUNTY:						
Eugene Leland Memorial Hospital	Riverdale	87	**	87	87	**	87
Prince George's General Hospital	Cheverly	102	**	102	102	**	102
Warren Hospital	Laurel	17	—	17	17	—	17
	ST. MARY'S COUNTY:						
St. Mary's Hospital	Leonardtown	35	10	45	35	10	45
	SOMERSET COUNTY:						
Edward W. McCready Memorial Hospital	Crisfield	30	8	38	30	8	38
	TALBOT COUNTY:						
Easton Memorial Hospital	Easton	83	25	108	67	20	87
	WASHINGTON COUNTY:						
Washington County Hospital	Hagerstown	175	10	185	132	10	142
	WICOMICO COUNTY:						
Peninsula General Hospital	Salisbury	147	30	177	147	30	177
	Totals for Counties	1853	214	2067	1761	203	1964
	BALTIMORE CITY:						
Baltimore City Hospitals	4940 Eastern Avenue	513	*	513	513	*	513
Bon Secours Hospital	2025 W. Fayette Street	142	—	142	142	—	142
Church Home and Hospital	Broadway and Fairmount Avenue	165	—	165	165	—	165
Franklin Square Hospital	110 N. Calhoun Street	177	25	202	158	15	173
Hospital for Women of Maryland	Lafayette Avenue and John Street	124	—	124	124	—	124
Johns Hopkins Hospital	Broadway and Monument Street	767	217	984	656	217	873
Maryland General Hospital	Linden Avenue and Madison Street	233	9	242	228	7	235
Mercy Hospital	Calvert and Saratoga Streets	262	25	287	256	25	281
Provident Hospital	1514 Division Street	—	125	125	—	125	125
St. Agnes Hospital	Wilkens and Caton Avenues	221	—	221	184	—	184
St. Joseph's Hospital	1400 N. Caroline Street	230	20	250	230	20	250
Sinai Hospital	1714 E. Monument Street	300	—	300	300	—	300
South Baltimore General Hospital	1211 Light Street	138	12	150	127	8	135
Sydenham Hospital	Harford Road and Herring Run	100	*	100	100	*	100
Union Memorial Hospital	33rd and Calvert Streets	341	—	341	341	—	341
Volunteers of America Hospital	418 W. Lexington Street	40	—	40	40	—	40
West Baltimore General Hospital	Rayner Avenue and Dukeland Street	186	**	186	186	**	186
University Hospital	Redwood and Greene Streets	354	81	435	354	81	435
	Baltimore City Totals	4293	514	4807	4104	498	4602
	County Totals	1853	214	2067	1761	203	1964
	State Totals	6146	728	6874	5865	701	6566

* Non-whites admitted to all patient facilities.

** Admit non-white on emergency.

MENTAL HOSPITALS

BED COMPLEMENT AND NORMAL BED CAPACITY

BY BED ASSIGNMENT BY RACE

TABLE I

Name of Hospital	Location	Complement			Normal		
		White	Non-white	Total	White	Non-white	Total
	ALLEGANY COUNTY:						
Sylvan Retreat	Cumberland	96	*	96	52	*	52
	ANNE ARUNDEL COUNTY:						
Crownsville State Hospital	Crownsville	—	1234	1234**	—	1044**	1044
	BALTIMORE COUNTY:						
Aigburth Manor	Towson	22	—	22	22	—	22
Haarlem Lodge	Catonsville	69	—	69	42	—	42
Relay Sanatorium	Relay	35	—	35	35	—	35
Sheppard and Enoch Pratt Hospital	Towson	300	—	300	238	—	238
Spring Grove State Hospital	Catonsville	2214	—	2214	2013	—	2013
	BALTIMORE CITY:						
Gundry Sanatorium	Athol and Frederick Road	41	—	41	51	—	51
The Seton Institute	6420 Reisterstown Road	396	—	396	396	—	396
Phipps Psychiatric Clinic (Johns Hopkins Hospital)	Broadway and Monument Street	87	—	87	87	—	87
Pinecrest Sanatorium	600 S. Chapelgate Lane	29	—	29	28	—	28
	CARROLL COUNTY:						
Springfield State Hospital	Sykeaville	3011	—	3011	2688	—	2688
	DORCHESTER COUNTY:						
Eastern Shore State Hospital	Cambridge	492	—	492	466	—	466
	FREDERICK COUNTY:						
Riggs Cottage Sanatorium	Ijamsville	30	—	30	55	—	55
	HOWARD COUNTY:						
Pinel Clinic	Ellicott City	33	—	33	33	—	33
Elkridge Farm	Ellicott City	18	—	18	18	—	18
	MONTGOMERY COUNTY:						
Cedarcroft Sanatorium	Silver Spring	50	—	50	50	—	50
Chestnut Lodge Sanatorium	Rockville	50	—	50	50	—	50
	PRINCE GEORGE'S COUNTY:						
Laurel Sanatorium	Laurel	85	—	85	85	—	85
	Totals	7058	1234	8292	6409	1044	7453

* Non-whites admitted.

** Space for 164 additional beds when help is available. 307 patients (on date of survey) were in hospital in temporary beds not counted in complement.

Normal at State mental hospitals is based on 45 square feet to bed plus 25 square feet per patient in day rooms. For infirmary patients and criminal insane the beds are at 50 square feet.

TUBERCULOSIS SANATORIA

BED COMPLEMENT AND NORMAL BED CAPACITY

BY BED ASSIGNMENT BY RACE

TABLE J

Name of Hospital	Location	Complement			Normal		
		White	Non-white	Total	White	Non-white	Total
	BALTIMORE COUNTY:						
Eudowood Sanatorium	Towson	194	—	194	194	—	194
Maryland Tuberculosis Sanatorium	Mt. Wilson	199	11	210	199	11	210
Mt. Pleasant Hospital	Reisterstown	60	—	60	60	—	60
	BALTIMORE CITY:						
Baltimore City Hospitals	4940 Eastern Avenue	280	*	280	280	*	280
	CARROLL COUNTY:						
Maryland Tuberculosis Sanatorium	Henryton	—	357	357	—	538	538
	FREDERICK COUNTY:						
Maryland Tuberculosis Sanatorium	State Sanatorium	523	—	523	523	—	523
	WICOMICO COUNTY:						
Maryland Tuberculosis Sanatorium	Salisbury	60	—	60	78	—	78
	Totals	1316	368	1684	1334	549	1883

* Non-whites admitted.

NURSING HOMES AND INSTITUTIONS FOR CHRONICS

TABLE K

Name of Institution	Location	Bed Complement
Nursing Homes:	*ALLEGANY COUNTY:*	
Collins Nursing Home	Cumberland	6
Crump Convalescent Home	Cumberland	9
	ANNE ARUNDEL COUNTY	
Forest Avenue Nursing Home	Dorsey	9
	BALTIMORE COUNTY:	
Bonny View Nursing Home	Catonsville	5
Coale's Nursing Home	Catonsville	14
Catonsville Home for Aged	Catonsville	25
Mrs. Jane Hitchcock	Catonsville	6
Hoods Convalescent Home	Catonsville	57
House in the Pines Nursing Home	16 Fusting Avenue	26
Katherine Robb Nursing Home	Pikesville	13
Yienger Nursing Home	Harrisonville	7
Armacost Nursing Home	Stoneleigh	29
	BALTIMORE CITY:	
Alberta Convalescent Home	4013 Liberty Heights Avenue	14
Anderson Rest & Convalescent Home	3605 Hillsdale Road	22
Ashburton House	3520 North Hilton Road	35
Beech Hill	6028 Old Harford Road	12
Clifton Nursing Home	3502 Clifton Avenue	8
Cold Spring Home for Aged	2101 W. Cold Spring Lane	55
Colonial Nursing & Conv. Home	Catonsville	9
Crawford Retreat	2117 Denison Street	21
Edgewood Nursing Home	6000 Bellona Avenue	55
Elmhurst Nursing Home	1708 Eutaw Place	34
Feinblatt Nursing Home	1701 Ellamont Street	17
Finley Nursing Home	2601 Roslyn Avenue	16
Garrison Nursing Home	2803 Garrison Boulevard	10
Harford Convalescent Home	4700 Harford Road	47
Haven Nursing Home	4514 Garrison Boulevard	16
Home of Our Lady	1302 W. Lexington Street	18
Jewish Convalescent Home Society	4601 Pall Mall Road	11
Parkmont Nursing Home	4212 Parkmont Avenue	10
Pine Ridge Convalescent Home	4703 Hampnett Avenue	19
Eleanor Shipley	4112 Edmondson Avenue	5
The Wayne	3203 Brightwood Avenue	5
Twilight Rest & Nursing Home	1913 Eutaw Place	14
Opitz Home for Aged & Invalids	Edmondson Avenue & Nunnery Lane	41
Mrs. Mabel Harry	625 St. Johns Road	4
Miss Margaret Judge	132 W. Lafayette Avenue	8
Agnes McKenna Memorial Clinic	212 Stony Run Lane	21
The Misses Gaddis	218 Ridgewood Road	11
Mt. Carmel Nursing Home	2476 Shirley Avenue	22
Ventnor Lodge	526 S. Chapelgate Lane	23
Mrs. Virginia Lewis	4203 Springdale Avenue	4
Wheeler Nursing Home	1700 Park Avenue	15
	CARROLL COUNTY:	
Fringer Nursing Home	Westminster	5
Hale Home for the Aged	Finksburg	5
Mumford Home	Westminster	5
Rowe Nursing Home	Union Bridge	6
	CECIL COUNTY:	
Harmony Nursing Home	Conowingo	13
	DORCHESTER COUNTY:	
Mrs. Katie Tregoe's Home	Cambridge	3
	GARRETT COUNTY:	
Kiser Nursing Home	Mt. Lake Park	24
	HARFORD COUNTY:	
Harford Convalescent Home	Bel Air	20
	KENT COUNTY:	
Crew Convalescent Home	Chestertown	7
Mrs. Ida King	Millington	6

NURSING HOMES AND INSTITUTIONS FOR CHRONICS

TABLE K—*Continued*

Name of Institution	Location	Bed Complement
	MONTGOMERY COUNTY:	
Christ Child Convalescent Farm	Rockville	27
Cur Lu Rest Home	Takoma Park	8
Mrs. Elizabeth Gaither	Gaithersburg	5
George Convalescent & Rest Home	Takoma Park	14
Jolliffe Nursing Home for Aged	Silver Spring	14
Mrs. Jolliffe	Takoma Park	17
Mrs. Lillie B. Melton	Silver Spring	12
Oak Drive Nursing Home	Silver Spring	8
Resthaven Convalescent Home	Takoma Park	5
Mrs. Louis Moody	Takoma Park	6
Sandridge Rest Home	Rockville	10
Sinclair Convalescent Home	Kensington	5
Spring Villa Convalescent Home	Takoma Park	13
Waverly Sanitarium	Rockville	24
Witzke Nursing Home	Takoma Park	4
Woodlawn Sanatorium	Rockville	13
Mrs. Olive Wright	Takoma Park	5
Youngerman's Nursing Home	Rockville	5
	PRINCE GEORGE'S CO.:	
Mother Jones Rest Home	Hyattsville	31
	QUEEN ANNE'S COUNTY:	
Mrs. Legg's Home for Welfare Patients	Millington	6
Melvin Nursing Home	Millington	3
Palmatory Nursing Home	Millington	10
Robbins Rest Home	Millington	12
	WASHINGTON COUNTY:	
Eshlman's Nursing Home	Maugansville	4
Gateway Nursing Home	Route 40	18
Hillcrest	Hagerstown	40
	WICOMICO COUNTY:	
The Lemon Home	Salisbury	15
Sallie Wright Nursing Home for Welfare Patients	Salisbury	24
Total bed complement in Nursing Homes		1260
Homes for Chronics:	*BALTIMORE COUNTY:*	
St. Gabriel's Home for Convalescent Girls	Catonsville	24
	BALTIMORE CITY:	
James Lawrence Kernan Hospital	Windsor Mill Road	89
Happy Hills Convalescent Home for Children	1708 Rogers Avenue	68
Mercy Villa Nursing Home	Bellona Avenue, Govans	24
Home for Incurables	700 West 40th Street	166
Levindale Hebrew Home and Infirmary	Belvedere & Greenspring Ave.	175
Jenkins Memorial, Inc.	1000 Caton Avenue	88
Aged Women's and Aged Men's Home	1400 W. Lexington Street	32
	WASHINGTON COUNTY:	
Infant & Child Health Center, Inc.	Hagerstown	14
Total bed complement in Homes for Chronics		680
Total bed complement in Nursing Homes		1260
Beds for Chronics at Baltimore City Hospitals		451
Grand Total		2391

SPECIAL HOSPITALS

BED COMPLEMENT AND NORMAL BED CAPACITY

BY BED ASSIGNMENT BY RACE

TABLE L

Name of Hospital	Location	Complement			Normal		
		White	Non-white	Total	White	Non-white	Total
	ALLEGANY COUNTY:						
Reeves Clinic	Westernport	17	—	17	17	—	17
	BALTIMORE CITY:						
Baltimore Eye, Ear and Throat Charity Hospital	1214 Eutaw Place	51	14	65	51	14	65
Beck Diagnostic Clinic	100 East 23rd Street	14	—	14	14	—	14
Children's Hospital School	Greenspring Avenue	115	15	130	115	15	130
Doctor's Hospital	876 Washington Boulevard	8	—	8	8	—	8
Presbyterian Eye, Ear and Throat Hospital	1017 E. Baltimore Street	28	12	40	28	12	40
	WASHINGTON COUNTY:						
Fleming Eye, Ear, Nose and Throat Hospital	Williamsport	26	—	26	26	—	26
	Totals	259	41	300	259	41	300

Local Plans for Hospital Construction

In order to integrate into the considerations and planning of the Hospital Survey Committee the local plans for expansion of existing facilities and the construction of new medical facilities, administrators were requested to include as a part of their reports information on such plans. It was learned that some groups were giving active consideration to building programs and, in some cases, the plans were well advanced.

Because of the stimulus that was given to thinking along this line as a result of the enactment of Public Law 725 and the subsequent publicity, it was felt that a resurvey of this feature should be made. A questionnaire was prepared and a letter drafted and addressed to the Presidents of the Boards of the hospitals. Because consideration being given to construction, in many cases, was embryonic and uncrystallized, it was difficult to secure concrete facts with regard to the programs. The rapidly changing estimates on costs of construction also made it difficult to arrive at any dependable estimation of total costs involved. From their reports, however, it was apparent that many communities were cognizant of the need for new or additional medical facilities.

Twenty-six proposed projects were reported. Dollar estimates were reported on eighteen of these projects, amounting to a total of $7,590,000. This compilation does not include the State programs for the tuberculosis sanatoria, chronic disease hospitals nor the mental hospitals.

Funds reported available for the planned projects total $2,360,000.

This compilation of projected plans has been made for use during the study of allotment of additional facilities. The fact that the projects have been made a matter of record does not in any way establish a priority for them since priorities for projects will be based on established needs.

The effect of this reported planned construction will, however, affect the number of other facilities assigned to the area in the final plan.

State Legislation

A study of Public Law 725 disclosed that States will, in most instances, require three pieces of legislation in order to fully participate in its benefits.

Under Section 623(a), "Such State must (7) provide minimum standards for the maintenance and operation of hospitals which receive Federal aid under this part."

This, in effect, requires a State licensing law. Maryland already had adequate legislation in this respect, having enacted Chapter 210, Sections 496A to 496K to Article 43 of the Annotated Code of Maryland (1939 Edition), which is "A Law Authorizing the State Board of Health to Promulgate Rules and Regulations Prescribing Certain Minimum Standards for Hospitals."

It is also necessary that each State enact a Hospital Survey and Construction Act in order to delegate proper authority to the State agency or agencies designated as the body or bodies to function under the Act.

A model law for this purpose was prepared by the Council of State Governments. The Committee is at present studying the model law for the purpose of adapting it to the needs of Maryland.

Legislation should be enacted which will perform this function.

The third piece of legislation necessary is a law which will enable the counties and municipalities to participate in the program by authorizing them to receive Federal funds, raise funds locally, and expend such funds for the construction and operation of hospital facilities approved by the appropriate State agency and determined to be necessary by the Hospital Survey Committee.

This law should include the following provisions:

1. Authorize the counties and municipalities to raise funds by taxation or by the issuance of bonds or other collateral for the construction, equipping and operation of health facilities.
2. The issuance of bonds and other types of collateral should be permitted outside such statutory limitation on indebtedness as may be established by other laws.
3. Authorize the acceptance and use of Federal funds for the purposes of this program.
4. Projects financed out of such funds must have the prior approval of the State agency established as the administering body under the proposed Hospital Survey and Construction Act, and be consistent with the State plan for health facilities and services developed by the Hospital Survey Committee.

Recommendations

The Committee considers it important and necessary to submit certain recommendations at this time even though its work is incomplete.

1. Legislation in the form of a Hospital Survey and Construction Act must be enacted before the benefits of Public Law 725 can become available to the State.

   This legislation should designate a single State agency as responsible for the construction phase of the program and delegate such authority as is required to function under Public Law 725.

   With the apparent need for additional facilities in all categories, prompt action should be taken on this legislation in order that the construction of needed facilities may begin as soon as the State Plan is approved by the Surgeon General. It is recommended that this legislation be enacted.

2. It is very essential that there be enacted an enabling law which would permit the political subdivisions to participate in hospital construction programs.

   It is felt that some communities will probably be unable to participate in the program if the local funds must be derived entirely from private contributions. In such cases, public funds must be made available if the needed facilities are to be constructed.

   The Committee recommends the enactment of legislation for this purpose.

3. The deplorable conditions which were found to exist in many of the nursing and convalescent homes and the recognized rapidity with which such institutions are springing up focuses attention on the need for chronic disease hospitals.

   The present planned chronic disease hospitals which are to have a total capacity of 1300 beds will fall short of the apparent immediate need for such facilities. It is, therefore, strongly urged that one chronic disease hospital now under construction at Salisbury be completed and put into service as soon as possible and that funds for the construction of the other hospitals, one to be located near Baltimore and the other near Hagerstown, be appropriated and construction started at the earliest possible time.

   It is to be hoped that such facilities, when constructed, will be located immediately adjacent to general hospital facilities.

4. Immediate action should be taken to ameliorate the present unsatisfactory conditions which exist in the State mental hospitals.

   The Board of Mental Hygiene is fully cognizant of its problems. It has submitted requests for the construction of housing facilities for personnel as of first importance in order to induce people to accept employment in the institutions. The need for construction of additional patient facilities is recognized as imperative, but would make no contribution to the solution of the problems in this field until personnel is available in sufficient force to render adequate service to the occupants of the beds so provided.

It is, therefore, strongly recommended that favorable action be taken on the requests of the Board of Mental Hygiene and that adequate funds be appropriated to put into physical existence the additional facilities included in the programs of the several State mental hospitals.

5. The University of Maryland has included in its projected plans a psychiatric unit to be installed at the University Hospital. This project has the endorsement of the Board of Mental Hygiene.

   This unit would provide:

   (a) A training center for doctors, nurses and personnel

   (b) An opportunity for research

   (c) Emergency facilities

   (d) Care for cases whose prognosis indicates maximum possibility of recovery in a comparatively short period of hospitalization

   (e) Out-patient services for potential institutional cases and post-institutional care for paroled patients.

   This project is recommended as an important part of the Mental Hygiene Program.

6. The original budget granted the Committee will be exhausted before its work has been completed. A request for supplemental State funds in the amount of $2,177.80 has been filed by the State Planning Commission with the Board of Public Works.

   This request was prepared after a study of the needs of the Committee to the completion of its work which, it is estimated, will be reached by June 30, 1947. Matching Federal funds, which will become available for survey purposes, were also taken into consideration.

   It is urged that this request for supplemental funds be granted immediately to guard against any interruption in the work.

The Study and Plan

The Committee, having completed its field survey, has entered the study and planning stage of its work.

This second stage of the work will include:

1. An analysis of existing facilities.
2. The establishment of hospital areas or communities in line with geographic, industrial, commercial and transportation factors.
3. A determination of the medical facility needs within each area in line with the present population of the area, the trends in population, and other related factors, including racial apportionment in each of the categories.
4. Consideration of a plan for the interrelation of the facilities and services of the various areas.
5. An investigation of the ability of the areas to finance the construction and continuing operation of the facilities.
6. Consideration of the availability of personnel for the staffing of the facilities determined to be needed.
7. A determination of the relative urgency of the projects found to be needed.

It is expected that this work will have been completed by June 30, 1947.